McGRAW-HILL INSURANCE SERIES
RALPH H. BLANCHARD, EDITOR

Insurance

ITS THEORY AND PRACTICE IN THE UNITED STATES

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Insurance

ITS THEORY AND PRACTICE IN THE UNITED STATES

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THIRD EDITION
THIRD IMPRESSION

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INSURANCE: ITS THEORY AND PRACTICE IN THE UNITED STATES

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To those, in the insurance business and elsewhere, from whom I have learned its problems and ideals.

PREFACE TO THE THIRD EDITION

Nine years have passed since the publication of the second edition of this book. In that period, the business of insurance has grown at an accelerating pace. Policy contracts have been liberalized, governmental regulations have been changed, and new problems have arisen. Although basic principles as stressed in the earlier editions have not altered, practices have changed in many respects, and the sharp lines of demarcation between types of carriers have tended to become blurred.

These conditions have indicated the desirability of a new edition. Advantage has been taken of the opportunity so presented to revise the entire text. The basic plan of treatment has not been changed, but each chapter has been thoroughly revised, in part at least, rewritten and brought up to date. Some rearrangement has been made in the order of treatment of the several topics.

The author extends his thanks to those whose comments on the earlier editions have assisted him in this revision.

A. H. Mowbray

Berkeley, Calif.
August, 1946

PREFACE TO THE FIRST EDITION

After some twenty years of active work in the business of insurance, including technical and executive service in life insurance and workmen's compensation and liability insurance and service as examiner and actuary in state insurance departments, the author, in 1923, undertook to give the insurance courses at the University of California. The first of these was a general introductory course designed for two purposes: (1) to give a general understanding of the theory and practice of insurance to students of economics and commerce who would do no further work in that field; and (2) to serve as a foundation for students who would specialize in insurance, presumably with the intention of entering the insurance business after graduation.

The various available texts were tried out but were not found suitable for this course. The broad general principles which underlie the insurance business in all its branches seemed to be buried under, or confused with, a mass of details of practice in the individual branches. In short, it seemed that existing texts were in the form of a series, loosely strung together, dealing with the several branches of the insurance business rather than a unified general treatment.

This situation reflected the attitude of practical insurance men, among whom the author has found a general feeling that their own particular branch is unique and has little or nothing in common with the other great branches of the business. This view is, of course, fostered by our statutory provisions classifying insurance into branches and restricting the rights of carriers to supposedly cognate lines. Such lack of unity in the business, which the author believes mistaken and which has been pointed out by others as inimical to the best interests of the business, seems to be due in part to the absence of literature emphasizing the unity of the business in its fundamental economic service and inherent problems.

This book is an attempt to fill that gap. Its plan has been tried out in lectures over a period of three years with apparent success. Of necessity, in emphasizing principles common to the insurance business as a whole, much detail of importance to the several branches has been forced into the background or omitted entirely. The author has endeavored in so doing to avoid presenting a distorted picture of any branch of the business.

No claim for originality of material is made. The author has drawn in part from existing literature, but his principal source has been his practical contacts with the business, and with the men in it during his active participation, and from his work as a consulting actuary since entering the teaching profession.

Having drawn from such wide and varied sources it is impossible to make adequate acknowledgment to all to whom it is due. The dedication is an inadequate attempt to give such acknowledgement. But certain individuals deserve special mention. Messrs. A. S. Holman, Joy Lichtenstein, A. J. Kislitzen, and Frederic J. Perry, of San Francisco, have each read one or more of the chapters in Part II and have made valuable suggestions. Mr Lichtenstein also had his assistants read several chapters on casualty lines. Prof. Felix Flügel read the entire manuscript as a check against too technical expressions, and his criticism has led to improvement in presentation at many points.

Thanks are also due to the companies and bureaus who have courteously permitted reproduction of their forms in the Appendices, to Mrs. A. L. Collins for valuable assistance in the typing and preparation of the manuscript and in reading proof, and to Mr. William Leslie, who has read the entire galley proof.

The author's greatest indebtedness is to the editor of this series, Mr. R. H. Blanchard. But for his suggestion the work would probably not have been undertaken. His criticisms of earlier drafts of the manuscript have been invaluable and have led to clearer expression at many points. His patient urging has recued the work from the persistent pressure of other affairs.

While acknowledging assistance and inspiration from these many sources, the author takes sole responsibility for the statements made and the views expressed. He cannot expect all will

agree with him in every particular. He sincerely trusts that no serious error of factual matter will be found and that none will feel that he has presented a distorted picture of the great business to which his life has largely been given.

A. H. Mowbray

Berkeley, Calif.
January, 1930

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RISK

INTRODUCTION TO PART I

The insurance business is a social device for eliminating or reducing the cost to society of certain types of risk. This statement requires demonstration and explanation, which it is one purpose of this book to furnish. In order to do so, it is necessary to consider certain propositions in the theory of risk, the connection of which with the insurance business may not be immediately apparent, but a sound appreciation of which is fundamental to a proper understanding of the economic significance of that business.

These propositions are discussed in the first three chapters of Part I. Lest the reader infer from this discussion that the insurance business is not concerned with loss prevention, which is socially more desirable than insurance, it has seemed wise to add a chapter dealing with this subject.

CHAPTER I

RISK, ITS NATURE AND ECONOMIC SIGNIFICANCE

The view is widespread, even among many who are accustomed to carry insurance, that only those who suffer loss and receive indemnity obtain any real benefit from insurance. This view is quite incorrect. Paradoxical as it may seem, the promise to pay if a loss occurs may be fully as valuable as reimbursement after the loss. The reason why this is so is to be found in a consideration of the nature of risk and its economic significance.

Definition of Risk.—It is not necessary to define the term "risk" narrowly and precisely. A broad definition is needed to cover all that may be implied in the use of the term in connection with the insurance business. For the present it may be said

that *risk is the chance of loss.*[1] Two things are implied in this definition: first, uncertainty as to the outcome of some future event or events; second, loss as the result of at least one possible outcome.

Here arises, apparently, a certain logical difficulty, since this is an ordered universe in which events take place in accordance with natural laws in which chance can play no part. But the contradiction is only apparent. Occurrences may take place in accordance with fixed laws, but, if those laws are unknown to an individual or community or if all the forces at work on the particular subject matter are not known, then to that individual or community the precise outcome cannot be foreknown. Hence uncertainty may exist, and if one or more apparently possible occurrences involve loss, there is risk. An example of risk where the uncertainty is due to incomplete knowledge of natural laws is that due to earthquake; of risk where the uncertainty is due to lack of knowledge of all forces at work, that of destruction of a garage by fire, which may result from employees smoking contrary to orders, spontaneous combustion of oily waste not properly disposed of, or any one of a number of things which one might know would cause a fire if present, but the presence of which cannot be foretold.

It is possible that the outcome may be known to certain persons or communities and not to others. In the present state of civilization, however, with present means of communication, this is not likely to be the case except in a few more or less remote instances. If the precise outcome of an event is foreknown, there is certainty and, whether or not it involves loss, it is not properly termed a "risk." As knowledge of natural laws expands and control over the forces that may enter into a given situation increases, risks tend to be eliminated. For example, when house lighting by electricity was first introduced, fires due to electric current were common and there was a considerable risk involved, but with increased knowledge of safe practice and insistence on such safe practice, fires are much less likely to be

[1] This definition is of risk in the abstract. By a common custom of transfer of meaning the term "risk" is often used by insurance men to mean the concrete thing that is subject to the risk, such as a man or house or ship, on which insurance is desired.

caused by this hazard. There is still some risk, for occasionally mice or rats or chafing may remove insulation and cause short circuits and fires, but the degree of risk is much less than formerly. This illustration also shows that progress in scientific knowledge may, at least temporarily, increase hazard by introducing a new process into general use before all its dangers are known and proper safeguards worked out.

The discussion of this last point has indicated that risks may differ in degree. They differ in other ways and, since a working definition has been adopted that does not involve logical inconsistencies, the various aspects of risk may now be considered. The most important aspects from which the concept of risk may be studied are (1) its nature, (2) its degree, and (3) its value.

Nature of Risks in Economic Life.—Since the insurance business is not concerned with all classes of risks, but only with the particular class which may be called "pure risk," it is well to give consideration first to the classification of risks according to their nature.

There are two categories into which economic risks may be divided according to their nature:

1. Speculative risks.
2. Pure risks.[1]

In both these classes there is uncertainty as to the outcome of the event under consideration, with at least one outcome producing loss; in the case of speculative risks, there is also a possible outcome producing profit which could not result from pure risks. As an example of the first class may be cited any new commercial or manufacturing enterprise. Even under

[1] This terminology is the author's and follows from his definition of risk. The discussion of the theory of risk has not yet reached the stage of a generally accepted terminology. Willett distinguishes positive and negative risk. "There is the possibility that existing wealth may be lost by its owner, and the possibility that expected future wealth may never be obtained. We may distinguish these forms of loss as positive and negative." (A. H. Willett, "Theory of Risk and Insurance," pp. 38*ff.*) He also distinguishes between static and dynamic risk, depending on whether or not the chance of loss arises out of dynamic conditions or would be present even in a static state. Hardy classifies risks into five types in accordance with their origin. (C. O. Hardy, "Risk and Risk Bearing," p. 2.) Other writers have used other bases of classification.

the best laid plans there is more or less uncertainty whether the enterprise will succeed or fail. If it succeeds, it will yield a profit. Failure means loss. A simpler example of the principle of speculative risk is the ordinary wager on the toss of a coin or throw of dice. There is uncertainty as to outcome, and for either party a chance of gain and of loss. Possession of any form of destructible property is an example of exposure to pure risk, since its destruction is always possible but not certain, and its destruction results in loss while its preservation does not of itself yield any increase in value or profit.

Degree of Risk.—In dealing with speculative or with pure risk, one finds different degrees of risk, depending on the uncertainty or the probability of loss or gain. If it is foreknown that the loss is inevitable and there is no uncertainty even as to the time when it will occur, then clearly there is no risk however great may be the loss. Cases involving this type of certainty are rare except where property is destroyed in promoting some other cause of gain, as when coal is burned to produce steam in a boiler. A case is occasionally found, however, where the certain loss is not brought about as a means of gain. For example, a number of years ago a portion of the city of Honolulu was burned by the federal authorities because of infection with bubonic plague. The loss of the buildings was certain and there was no risk in respect of those buildings.[1] There was risk of loss on surrounding buildings, owing to the uncertainty lest the fire get beyond control and destroy them, a risk that actually resulted in heavy loss[2] for the insurance companies covering them, for the fire did get beyond control. If, on the other hand, it is certain that a particular loss cannot occur, for example, the destruction by fire of a masonry dam, then also there is no risk.

Thus there is a distinction between risk and probability of

[1] It may be alleged that even here the loss was brought about as a means of gain, namely, the removal of the plague danger, or that there was no real loss since the infection had already destroyed the value of the premises. These contentions may be admitted as sound but the point is not essential to the argument. The case is merely cited as an example of the absence of risk associated with total loss. It is admitted that such cases are rare except when the destruction is a part of a large constructive process.

[2] About 30 years later Congress by special act provided for reimbursement to the companies.

loss. The probability may vary from zero (certainty of no loss) to 100 per cent (certainty of loss) but at each extreme there is no risk. The greatest uncertainty exists when the probabilities are evenly balanced, for example, in a wager that a coin which is to be tossed will fall head. The risk diminishes in passing from this degree of probability to either extreme. The entrepreneur usually weighs the risk (chance of loss) against the chance of gain in forming his decision whether to undertake an enterprise. This is natural and proper since, if the prospect of gain is sufficient, he will be justified in assuming some risk. It would hardly seem that the individual is justified in allowing his attitude toward protection against a pure risk to be influenced by the degree of risk if the amount of possible loss is, for him, substantial. For when the event occurs, he suffers, and the smallness of the degree of risk, owing to the improbability of occurrence, does not in this case mitigate his suffering. This false type of reasoning is, however, not uncommon. As an example, the case of a man whose home adjoined a station of the fire department of his city may be cited. Feeling that, owing to the promptness with which the fire would be fought, it was almost certain that only the smallest losses would be incurred in the event of a fire, he carried only a very small amount of insurance, *i.e.*, no insurance against total loss. When, under conditions of high wind and exceeding dryness, the entire section of the city in which he lived was destroyed in a conflagration, he was caught and had to bear alone all but a minor fraction of his loss. To the insurance carrier, on the other hand, consideration of a degree of risk is important since, as will be shown later, it is the determining factor in considering whether a policy should be issued and on what terms.

In most pure risks met in economic life, the probability of loss is so small relative to certainty of total destruction that the degree of risk and the probability of loss are approximately equal. Because of the expense involved, the insurance business cannot effectively deal with risks approaching the maximum uncertainty, those in which the probability of loss approaches 50 per cent.

Value of Risk.—Risk may also be considered in relation to the amount of loss that may occur and may be evaluated. There

are two possible definitions of the *value* of risks. From the point of view of both the individual and the society, the importance or value of any particular risk hinges largely on the amount of possible loss. It is, however, not the absolute size of a possible loss that is of controlling importance, but the size in relation to the available margin for contingencies. If the individual exposed to a risk is of low economic strength with but a narrow margin of property beyond that required for adequate subsistence, even a very small loss may be more than he can stand without evident suffering. On the other hand, a man whose resources run into the millions might suffer little hardship, though a loss ran to several thousand dollars. Again, the pressure of loss depends upon its incidence. Even a man of large wealth might be put to some embarrassment to meet a sudden immediate need amounting to a relatively small sum. But, though the cause be sudden and unforeseen, if the liquidation can be spread over a period of time, often no great difficulty will be involved in meeting a large loss.

From a different point of view, a very useful measure of a value of risk, one that, as will be apparent later, lies at the foundation of the insurance business, is that known as the "expectation of loss," which is the product of the amount at stake and the probability of loss. If, for example, $10 is wagered on the toss of a coin, the expectation of loss is $5, since the probability of loss is one-half and the amount at stake is $10. Since by probability of loss is meant the proportion of total ventures which, according to statistical evidence or a priori reasoning must result in loss (the definition ordinarily used in discussions of the mathematical theory of probabilities),[1] it is evident that, management expense or profit not being considered, the expectation of loss is the amount one would expect to pay another to take his place by becoming exposed to the risk. The latter would, if he entered into enough such arrangements, suffer no loss in the long run.

This is the principle underlying the conduct of many gambling enterprises. If the proprietor of a gambling establishment had a sufficient fund to cover a temporary adverse run and, for the time, did not have to consider expenses, he could provide a per-

[1] For a discussion of the logical foundation for this definition see J. M. Keynes, "A Treatise on Probability."

fectly fair deck of cards, charge a patron 25 cents for the privilege of cutting them, agree to pay $1 if a spade (or any other agreed suit) were cut, and come out even in the long run. Were he to charge a few cents more, he would be able to pay expenses and have a margin of profit. He must lose, *i.e.*, pay, once in four times because one-fourth of the cards are of each suit and the chance of loss to him is one-fourth. The value of the risk, *i.e.*, the net price he must charge, is the product of this chance by the prize. To the value of the risk he must add a margin for his expense and profit.

This principle of probability will be discussed further in a later chapter. The point to be established here is that *expectation of loss* is a measure of value of risk.

Risk an Economic Burden.—It has been indicated that, to the man living close to the poverty line, a loss of a small amount may be a catastrophe. Even to the man of wealth, any substantial loss may be a sufficient blow to call for some readjustment of his affairs. If, for example, it were not possible for one to be reimbursed by insurance for loss by fire, shipwreck, or similar occurrence and if one had no other means (surplus), one might face ruin or at best a serious reduction in economic status. A classical example of a man of position so brought low is Antonio in the "Merchant of Venice." Of course, this would be the result, whether the risk were a pure risk and unavoidable as a risk, such as the loss of a home by fire caused by lightning or earthquake, or one undertaken as a part of a speculative venture in the hope of avoiding loss and of obtaining a profit. Were such losses to happen to any substantial part of a community there would be, it is hardly necessary to point out, a heavy social loss, a loss greater than the actual value of the property destroyed, by reason of the consequent general reduction of community standards.

Prudent men do not willingly expose themselves to such losses but, if they cannot rid themselves of the risk, accumulate a surplus or sinking fund to meet the contingency. The plain common sense of such a policy is expressed in the old adage, "Put something aside for a rainy day." Although thrift and saving are generally useful to society as a means of accumulating capital, such individual sinking funds are not often employed in as useful undertakings as are funds not impressed with this

quasi-trust character. Society then loses to the extent of the excess of the potential over the actual service value of such reserved funds. Further, the reserved funds could not safely be accumulated gradually, for there would be no assurance that the loss might not occur before sufficient funds had been built up to meet it, and their purpose thereby be defeated. Rather, the funds must be available step by step as destructible property is acquired. Because of the difficulty of making such provision, men are deterred from entering into ventures that expose them to risks or, if they do venture, do so only on terms involving large opportunities for profit. This inability to secure certain services at a reasonable cost is probably the heaviest social burden imposed by risk.[1]

Thus society suffers from the existence of risk, either through exposure to the chance of reduction in general well-being, unproductive use of capital, or failure to secure desired advantages.

Risk and Credit.—Important as the burden of risk upon society would be under the simplest conditions, its weight is enhanced in a society living under a highly organized credit economy. The lender of capital desires a return in the form of interest on his capital, but, were he to lose it in seeking that return, his condition would be worse than if he had allowed it to remain idle. Consequently, he will lend it for use only where the major risks to which it is exposed can be avoided. This is true of prudent investors, and particularly true of bankers and others charged with the investment of funds for the safety of which they are responsible. For example, bills of exchange in overseas trade are readily discounted when accompanied by proper documents, *including evidence of adequate insurance*, but not otherwise. Again, banks require, in addition to a

[1] As an example, reference may be made to the allegation that reluctance on the part of underwriters to furnish aviation insurance retarded the development of commercial aviation in the United States, because the risks were too great for individual entrepreneurs. The underwriters were reluctant because of the large value of the risk involved which, in turn, resulted from the large amounts at stake and the high degree of uncertainty of loss. See *The Literary Digest*, Sept. 5, 1925, p. 62, for detailed discussion citing *The Eastern Underwriter*. Since the time of this comment, the risk having been greatly reduced, insurance facilities adequate to our development of commercial aviation have been made available.

mortgage on real property, adequate fire insurance with a mortgagee clause attached giving them the first benefit of the insurance in all cases where insurable property is part of the security for their loan. More recently they have been demanding the elimination from such fire-insurance policies of the fallen-building clause which, if not eliminated, would leave them exposed to risk from a fire if the building were previously damaged by earthquake or other force which caused a material part of the building to fall before it took fire. Many lenders are also insisting on insurance protection against other hazards, such as windstorms, earthquakes, explosion, and falling aircraft. A large seashore hotel, standing on a bluff well above the water, has been insured for the protection of interested bondholders against loss by tidal wave.

It is true that speculatively inclined investors daily put their funds into enterprises in which the risk is great, sometimes knowingly, sometimes unwittingly. But the action of the unwitting can hardly be taken as typical. Where a risk is undertaken knowingly, there is a prospect of gain which is deemed by the speculator to exceed the prospect of loss. This may take the form of a higher rate of current return, a part of which is compensation for risk.

SUMMARY

1. Risk, which has been defined as "the chance of loss," involves, in varying combination, uncertainty as to the outcome of conditions, with loss as a consequence of at least some of the possibilities.

2. Under all circumstances, the existence of risk in itself, independent of the actual loss that takes place in some instances, is a social burden.

3. Where credit is extensively used as a basis of economic action, the burden of risk is increased.

4. Large social gains result if it is possible to reduce or eliminate risk, whether or not loss is prevented.

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Hardy, Charles O., "Risk and Risk-bearing," rev. ed., Chap. I.

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CHAPTER II

TYPES OF HAZARDS AND THE LAW OF LARGE NUMBERS

The preceding chapter was concerned with a discussion of the nature of risk and its character as an economic burden. The question was not raised whether risk actually exists in human affairs. That was rather taken for granted. Few, if any, would care to dispute the existence of risk. But how widespread is risk? In what affairs of life does it arise? These are questions that should not be passed over without comment, for the answers to them evidently delimit the sphere of usefulness of any device for reducing the burden of risk.

It is the purpose of this chapter to make some preliminary analysis of these questions, and also to outline the basis in natural phenomena on which rests insurance as a scheme for eliminating risk.

TYPES OF HAZARD

The first step in the analysis is naturally a discussion of types of hazards, for it is well to have in mind the range of risk-causing hazards to which business enterprises and personal affairs are subject, in order to appreciate both the place insurance has come to have in the economic order and what yet remains to be accomplished. In the following brief review of the several types of hazard to which mankind is subject, those mainly have been selected which may be covered in whole or in part by insurance.

Classification.—The hazards from which loss may arise may be classified according to what may be lost. From this point of view there are two major divisions, each based on the phase of life that is affected: personal and family risks, and business risks.[1]

[1] In connection with the second class it should be borne in mind that this study is concerned only with *pure* risk which does not include the entire range of business risks.

Personal risks may be subdivided into two groups: those of loss of income and those of loss of property. Loss of income to the individual or family may result from

1. Death.
2. Permanent disability.
   a. Total.
   b. Partial.
3. Temporary disability.
   a. Total.
   b. Partial.
4. Unemployment.
5. Superannuation.

Property loss may result from

1. Destruction or damage by
   a. Fire or lightning.
   b. Windstorm.
   c. Water leakage.
   d. Earthquake.
   e. Glass breakage.
   f. Explosion.
   g. Riot and civil commotion.
   h. Burglary, theft, or robbery.
   i. Forgery.
2. Liability to pay compensation for injury caused to the person or property of another where the injury is to
   a. The person of an employee.
   b. The person of a stranger.
   c. The property of another.
3. Extra expense:
   a. On account of illness or injury.
   b. For substitute facilities.

No attempt has been made to enumerate all the pure risks to which an individual or his family is subject. The list contains those which have been thought of sufficient importance to call for insurance and some for which insurance is not yet generally available.

Most of the risks to which personal affairs are subject also affect business. To these must be added the risk of loss of capital and income from several other causes, such as

Perils of transportation of goods on land and sea.
Hail, frost, and other causes of crop failure.

Defalcation or other misconduct of employees.
Failure of contractors to fulfill contracts.
Failure of depositories.
Unusual credit losses on sales.

LAW OF LARGE NUMBERS

Stability of Mass Phenomena.—The list of hazards to which mankind is subject is long and formidable. Every individual is subject to many risks each day from the cradle to the grave. There is scarcely any action not involving risk, and even inaction will not avoid it. Were there not qualifying factors, one would indeed be justified in looking upon the world and its affairs with a pessimistic eye. But at this point it should be recalled that the universe is governed by natural laws and that, if all conditions and forces operating could be foreknown, results could be foretold with assurance. Loss would still remain, but uncertainty, and therefore risk, would disappear. In a world so ordered, it would seem natural that the unknown and unobserved forces would tend to a balance, if enough cases could be observed, and that the uncertainty or risk present in the individual instance would disappear in the mass. This tendency of mass phenomena toward regularity has been demonstrated by experiment and has been formulated in the *law of large numbers*, which is the basis of all application of that branch of mathematics known as the "theory of probabilities."

The term "law of large numbers" was used by the eminent French mathematician, Poisson, in an article on "Researches on the Probability of Judgments,"[1] and is defined in terms of probabilities. It is therefore necessary to give a definition of this term. It would require a lengthy treatise to discuss the philosophical basis of the concept of probability as applied to the affairs of life, and this would divert attention from the main purpose of this book. However, the study of probability began with games of chance and, in this connection, probability may be defined exactly. The concept may then be carried over and applied within reasonable limits outside this field.

Consider the case of drawing balls from an urn containing a

[1] *Comptes rendus de l'Académie des Sciences*, Vol. I, p. 473, especially p. 478 (1835).

large number of balls, *e.g.*, 100, of which some, say 30, are white and the remainder red. If the person drawing is unable in drawing to identify any particular ball, he may draw any one of the lot. Since there are 100 balls, it may be said that there are 100 *possibilities* of selection. Under the same conditions there are 70 possibilities of selecting a red ball and 30 of selecting a white one. If the balls have been well mixed, all the possibilities are equally likely. It is then said that the chance or probability of drawing a white ball is 0.30 and that of drawing a red is 0.70. So, for example, the chance or probability that a perfect coin tossed at random will fall head is one-half since the total number of ways it can fall is two, and it can fall head in only one way. The definition of probability, from this point of view, is the ratio of chances favorable to success in the test to the total chances, all being, a priori, equally likely. If 10 red balls in the above scheme were removed and 10 black substituted, and the set again thoroughly mixed, the probability for drawing on a single trial a white ball would still be 0.30, a red, 0.60, and a black, 0.10. It is customary to designate a probability by p, and to append subscripts to refer to the particular probability in mind, as p_r, p_w, and p_b or p_1, p_2, and p_3, to refer to the probabilities of drawing a red, white, or black ball. In the example, $p_w = 0.3$, $p_r = 0.6$, and $p_b = 0.1$. The illustration, of course, might be complicated by changing the composition of the contents of the urn between each trial, in which case, the probabilities would also change on each trial. From this definition it follows that $p = 1$ means certainty of the occurrence. If all the balls in the urn were white, it would be certain that any ball drawn would be white.

Using this concept and notation, Poisson's law may be stated:

> If an event be tried repeatedly with probabilities $p_1 p_2 \ldots$ for success which may be constant, or may vary with each trial, then if the number of trials increase indefinitely, the probability that the difference between the average probability and the observed ratio of success will differ by less than any assigned quantity approaches 1 as a limit.[1]

This exact statement of the law is probably confusing to the nonmathematical student. In more popular but less exact

[1] Quoted by J. L. Coolidge, "Mathematical Probability," p. 65.

language it means that as the number of trials increases, the proportion of results approaches the underlying probability. For example, if a single card is drawn from a well-shuffled deck it may be any one of 52 but, since one-fourth of the cards are spades, the probability of drawing a spade is one-fourth. This does not mean that, if only four cards are drawn, one, and only one, will be a spade. It can be shown that there is a strong probability against this exact result. Nor does it mean that, if 40 are drawn, exactly 10 will be spades. It does mean that, as the number of trials is increased, the ratio of drawings of spades to the total drawings tends to become one-fourth, though the actual departure may be great. It will probably help to present a few illustrations of the operation of the law of large numbers in several widely separated fields as evidence that there is such a principle and that it may serve as a means of dealing with risk. Its operation is not subject to exact proof, as is that of the law of gravitation, except under purely mechanical and artificial conditions similar to those used in defining probability, and it should be borne clearly in mind that it is not put forward as a universal law. The important point is that, where it has been found by experiment to hold, the law of large numbers may be used to meet a situation causing loss, and to reduce, or even eliminate, the risk that is the cause of the loss. Instances of its operation will be cited, first from artificial mechanical schemes and then from the affairs of life.

Illustrations of the Law of Large Numbers.—It is obvious that no prediction can be made with any assurance whether an ordinary coin tossed at random will fall head or tail. Three college classes which tried the experiment of each member tossing 10 coins 10 times (equivalent to 100 tossings of a single coin each), reported the following results:

Number in class	Number of tosses	Heads	Percentage of heads
232	23,200	11,821	51
325	32,500	16,582	51
152	15,200	7,450	49
709	70,900	35,853	51 –

The tabulated results show an almost equal division into heads and tails in the aggregate for each class separately, as well as for the grand aggregate. Harald Westergaard, the Danish statistician,[1] tried a similar experiment by taking 100 sets of 100 drawings each from a bag containing an equal number of red and white balls. The mean number of white balls drawn per set was 50.11. In two cases the number was less than 40 (in one, it was 39), and in only three cases was it more than 60. In 70 per cent of the trials the number lay between 45 and 55. In only nine cases, however, was it exactly 50.

The value of a card on a single drawing from an ordinary whist deck is, of course, entirely a matter of conjecture. Arne Fisher tried the experiment of making 100 sets of drawings of 100 each from such a deck, recording the number of times an ace was drawn in each set. In 21 sets, seven aces were drawn; in 13 sets, eight; and in 15 sets, nine. According to the theory of probabilities the mean number should have been 7.69 aces per set. The actual was 7.45.[2] Many other instances of regularity in the results of a large number of experiments with mechanical devices could be cited.

Stability in such phenomena, however, has little practical value except to the gambler. But if the same tendency is present among risks of the types noted in the first part of this chapter, a way may be found to improve the situation by transferring the several risks from the individual to some professional risk carrier, which, having a very large number of instances of each, ought to experience such reasonable stability in loss as practically to eliminate the uncertainity, and destroy the risk *as risk*.

Such regularity *is* found in actual life, although events do not recur with the strict regularity of games of chance and mechanical devices. There is also evident in many cases slow steady change (such change as is known to statisticians as *secular trend*) and sometimes a seasonal variation within the year. But seasonal variations tend to operate in opposite directions and to counterbalance each other, as do the variations due to the business

[1] "Statistikens teori i grundrigs," quoted by Arne Fisher, in "Mathematical Theory of Probabilities," p. 136

[2] FISHER, *op. cit.*, p. 142.

TABLE I.—FATALITY RATES BASED ON THE NUMBER OF 2,000-HOUR WORKERS AS COMPARED WITH THE RATE BASED ON THE NUMBER OF MEN REPORTED AS EMPLOYED, 1903 TO 1913, INCLUSIVE, EXCEPT 1909[1]

State	Days worked per year (10-hour)	Actual number of men employed (10-year period)	Number of 2,000-hour workers	Fatalities for 10-year period			Fatalities per 1,000 men					
							Exceptional		Common		Total	
				Exceptional accidents	Common accidents	Total	Actual employees	2,000-hour workers	Actual employees	2,000-hour workers	Actual employees	2,000-hour workers
Illinois	156.7	664,866	521,053	116	1,585	1,701	0.17	0.22	2.38	3.04	2.55	3.26
Indiana	148.7	209,054	155,453	16	443	459	0.08	0.10	2.12	2.85	2.20	2.95
Maryland	242.8	a 47,611	57,957	......	104	104	....	....	2.18	1.79	2.18	1.79
Michigan	162.0	35,454	28,725	......	65	65	....	....	1.83	2.26	1.83	2.26
Montana	193.0	29,887	28,840	17	105	122	0.57	0.59	3.51	3.64	4.08	4.23
New Mexico	246.3	29,776	36,669	289	144	433	9.70	7.88	4.84	3.93	14.54	11.81
North Dakota	197.4	b 3,188	3,244	......	13	13	....	....	4.08	4.01	4.08	4.01
Ohio	149.5	452,089	337,891	35	1,296	1,331	0.07	0.10	2.87	3.84	2.94	3.94
Oklahoma	140.6	84,418	63,006	150	279	429	1.77	2.38	3.31	4.46	5.08	6.81
Pennsylvania (anthracite)	198.5	1,688,725	1,655,961	240	5,979	6,219	0.14	0.14	3.59	3.62	3.73	3.76
Pennsylvania (bituminous)	203.4	1,573,200	1,599,843	838	4,502	5,340	0.53	0.52	2.86	2.82	3.39	3.34
Texas	210.1	c 19,405	20,043	......	21	21	....	....	1.08	1.05	1.08	1.05
Utah	210.9	25,084	26,451	......	104	104	....	....	4.15	3.93	4.15	3.93
West Virginia	213.2	582,525	620,895	839	2,380	3,219	1.44	1.35	4.09	3.83	5.53	5.18
Total and average for the United States	190.9	6,604,289	6,288,531	3,713	20,652	24,365	0.56	0.59	3.13	3.28	3.69	3.87

a. Employees and fatalities for 8 years only.
b. Employees and fatalities for 5 years only.
c. Employees and fatalities for 4 years only.
[1] Condensed from table in "Coal Mine Fatalities in the United States 1870 to 1914," *U. S. Bureau of Mines Bulletin* 115, p. 61.

cycle, while slower long-time changes can generally be sufficiently anticipated. With due allowance for these changes, the law is found to hold with sufficient accuracy for practical use. Mortality tables used in life insurance, constructed at different times and places, show close resemblance in their general results. So do loss records in other lines of insurance.

The operation of this law in actual life with its practical value and its limitations probably cannot be better shown than by a study of Tables I and II of coal-mining fatalities in the principal coal-producing states for a 10-year period.

Table II.—Fatality Rates per 1,000 Men, by States, Compared on a Uniform Basis of 2,000-hour Workers[1]

State	1903	1904	1905	1906	1907	1908	1909a	1910	1911	1912	1913	Average
Illinois	3.40	3.70	4.33	3.37	3.32	3.40	.....	3.06	3.02	2.68	2.72	3.26
Indiana	3.86	2.44	2.99	2.10	3.15	3.51	.....	2.53	3.01	2.21	3.89	2.95
Maryland	1.94	1.59	2.02	.75	.....	....	.....	2.30	2.05	1.89	1.88	1.79
Michigan	3.04	2.24	3.23	1.82	1.88	1.71	.....	1.98	2.47	3.51	1.21	2.26
Montana	2.08	3.38	3.67	5.53	4.43	7.38	.....	3.24	4.12	2.31	6.00	4.23
New Mexico	9.77	3.85	2.87	9.32	8.65	7.16	.....	3.18	2.00	2.99	49.26	11.81
North Dakota	....	....	....	....	.....	7.55	.....	3.83	1.22	.....	8.78	4.01
Ohio	3.78	3.82	4.11	4.30	4.11	3.68	.....	4.18	3.28	3.67	4.37	3.94
Oklahoma	5.44	4.27	7.04	7.97	5.33	7.67	.....	7.80	4.92	16.01	3.21	6.81
Pennsylvania (anthracite)	3.71	4.24	4.02	3.91	4.28	4.33	.....	3.44	3.63	3.32	3.04	3.76
Pennsylvania (bituminous)	2.96	4.66	3.25	3.15	4.45	3.97	.....	2.89	2.99	2.48	3.07	3.34
Texas	....	....	....	....	.....	....	.....	1.62	1.63	.39	.71	1.05
Utah	3.29	5.56	5.20	2.21	2.18	2.06	.....	5.67	3.94	5.01	3.73	3.93
West Virginia	3.55	3.33	4.43	5.16	11.40	6.09	.....	4.35	4.77	4.34	4.07	5.18
Average for the U. S.	3.31	3.97	3.91	3.72	4.87	4.28	.....	4.03	3.78	3.32	3.58	3.87

a. Complete data not available.

[1] Condensed from table in "Coal Mine Fatalities in the United States 1870 to 1914," *U. S. Bureau of Mines Bulletin* 115, p. 62.

Fatalities in coal mining are influenced by a variety of factors, such as the type of coal, geological formation, mining practices, supervision, and care exercised by the individual miner. Table I shows, for each of the coal-mining states selected, the number of 2,000-hour workers, the number of fatalities, and the average fatality rates over a 10-year period. Table II shows similar rates for each year of the period.

In such states as Pennsylvania and Ohio, where the numbers employed are large, the rates from year to year show comparatively little change. In West Virginia, a very bad explosion caused a violent increase in 1907, and there seems to have been a general upward trend. Yet, even in this field, where conditions have long been notoriously disturbed, the large numbers involved gave (except for the catastrophe year) fairly stable results. On the other hand, in the states where the numbers employed are relatively small, such as North Dakota, Utah, and New Mexico, there is much irregularity.

Since these data were compiled there has been great improvement in the conditions of our coal mines as to the safety of the workers. The fatality rates for the decade 1930–1939 are much lower but show the same general characteristic—a tendency toward stability in the average over the years (after adjustment for trend), which is more marked in the states where the operations are extensive and the numbers employed are large than in states where the operations are limited and the numbers employed are small.[1]

Applicability of the Law of Large Numbers.—The principle of mass stability cannot be assumed to be universally applicable; in any new case, its applicability must be tested before it can be relied upon. Only in the case of those risks to which it is found to apply with reasonable approximation, is it possible to conduct a sound insurance business which can adequately eliminate or reduce risk. In view of the ordered character of the universe the law probably does apply to all physical phenomena, but some are of such infrequent occurrence that observations over long periods will be necessary to establish it, probably too long for practical use. For example, earthquakes seem to occur most irregularly. Yet it seems likely that, observed over a long period, regularity would be found.

Changes in Hazard.—It has been observed that, though the law of large numbers applies in widely scattered fields, some types of risk show a tendency to growth or decline in hazard. It may be well at this time to note some of the factors tending to produce such long-time changes in degree of risk, as well as the

[1] See "Coal-mine Accidents in the United States, 1939," *Bureau of Mines Bulletin* 444, especially Table 76 on p. 103.

departure of individual cases from the average and, at times, of averages from their normal value. It will be recognized that the development of knowledge of processes and conditions tends to eliminate uncertainty and therefore to reduce risk, though actual loss may not be decreased. Generally, however, in an effort to reduce cost, increased knowledge will be accompanied by greater precautions and safeguards, and losses also will be reduced.

Changes in economic conditions have an important bearing on the value of risks, because of their influence on the volition of those ordinarily subject to risk. The losses of fire-insurance companies always increase when the number of business failures increases. The explanation may be partly a tendency to economy which has reduced the safeguards usually present against accidental fires. But all too often the will to protection has not been present if, indeed, the policyholder in business difficulties has not yielded to the temptation to try to realize on "frozen inventories" by "selling them to the underwriters," as the occurrence of convenient, though supposedly accidental, fires has sometimes suggested. Risk due to volition of the insured is known among insurance men as "moral hazard." This risk has not been found to be subject to the law of large numbers and both for this and even more obvious reasons of public policy is uninsurable on any terms.[1] In a slightly different category is the absence of a will to safeguard, which is usually included under "moral hazard" but sometimes distinguished as "morale hazard."[2] Such absence of intent to protect does not prevent the operation of the law of large numbers but does tend to increase the degree of risk, making it higher in the individual case than the average of its class. This tends to make underwriters reluctant to take risks where its presence can be detected. The existence of insurance tends to create a certain degree of the latter type of hazard, by making the insured less concerned in the preservation of his property.

[1] Insurance carriers often find that they must pay losses due to moral hazard in risks they have assumed, but this statement reflects the views of skilled underwriters passing upon risks in which any considerable degree of moral hazard is indicated.

[2] The recent tendency to observe this distinction is to be commended as leading to clearer analysis.

SUMMARY

The aim of the present chapter has been to establish in the reader's mind:

1. That risk, which was found in Chap. I to impose, of itself and independent of actual losses sustained, an economic burden on society, is ever present in human affairs.
2. That, when the operations that give rise to risk are taken in the mass, there is a tendency to regularity such that, were the risks consolidated as those of a single individual, a high degree of certainty would replace a corresponding degree of uncertainty, and risk and the cost of risk would be eliminated or much reduced.
3. That the active desire to profit by insurance[1] interferes with the operation of the law and makes the risks of some persons uninsurable.

References

COOLIDGE, JULIAN L., "Mathematical Probability," Chaps. I–IV.
HARDY, CHARLES O., "Risk and Risk-bearing," rev. ed., Chap. II.
WILLETT, ALLAN H., "The Economic Theory of Risk and Insurance." Chaps. IV–VIII.

[1] Although the definition of insurance has been reserved for a later chapter, it seems reasonable in view of the widespread practice of insurance to assume that the references to insurance in this chapter will not cause difficulty. Some of the observations may profitably be reread in connection with Chap. XXI.

CHAPTER III

ELIMINATION OF RISK THROUGH TRANSFER AND AMALGAMATION

From the discussion of the law of large numbers as presented in Chap. II it will be apparent that, if the annual rate of destruction by fire of railroad freight cars is 3 per 1,000,[1] a road owning 50,000 cars might expect the destruction of 150 cars each year from this cause. In some years more would be so lost, in others less, but 150 would be the average annual loss.

Self-insurance of Large Operations.—Such a road, if it had a fluctuation fund to absorb irregularities, might charge into its operating costs each year 150 cars as lost by fire, and transfer the differences between this and the actual losses to or from such fund according to the year's experience. By this method it would be known that the showing of operating expense on which rates and dividends are in part based was not vitiated by an unknown risk. Such handling of a risk is *self-insurance.*[2]

Cooperative Risk Carrying.—If the railroad had only 1,000 freight cars, the expected annual loss would be but 3, a number quite too small to guarantee any appreciable uniformity. If 50 such roads, all having the same average rate of car loss, pooled their interests, and other conditions remained the same after pooling,[3] the total annual loss of the group would be as stable as in the case of the road with 50,000 cars. Some of the roads might lose no cars, and some 10 or more, but, over a

[1] This is a purely hypothetical figure.

[2] From the discussion in the latter part of this chapter it will be apparent that *self-insurance,* where there is sufficiently broad volume of isolated items to give an average experience and where a fluctuation fund is maintained is to be sharply distinguished from *noninsurance* where these conditions are not present and no other means are taken to nullify the risk *as risk.*

[3] See reference in Chap. II (p. 19) to the effect of insurance on morale and hazard.

period of time, the average annual loss would be 150 cars, and the roads could arrange their cost accounts as in the case of the larger road. In this case, the pool would set up the fluctuation fund.

Transfer to Professional Risk Carriers.—Instead of 50 roads, each having 1,000 cars, 500 roads, each having but 100 cars, may require protection against unusual annual loss. If, as before, other things are equal, and the risk the same for all, so far as it can be estimated, a pool might be formed with the same result. But, with so many members, the management of the pool would be much more difficult, involving more correspondence, accounting, and other similar work. The roads, however, would find the risk far too great to carry individually, since the expected loss of each would be but 0.3 per year and the actual loss might be an entire train of 10 or more cars. Upon the showing that the average annual rate of loss was 3 per 1,000, some person, or group of persons in a pool, might be willing, in return for an annual payment from each road at a rate a little higher than 0.3 per cent of the value of their cars, to assume the risk for them and, in the event of loss of any of their cars by fire, to indemnify or reimburse them for the loss; agreeing also that, if the fund so produced exceeded the actual losses developed and the expenses of operation, the net profit would be retained, and, if there were a net loss, that it should be borne by the person or group by whom the risk was assumed. Such transactions would, of course, be evidenced by written contracts. Instead of the arrangement being proposed by the roads it might be proposed by an individual, an *underwriter*, who has set himself up in the general business of issuing such contracts. The net effect would be the same.

Finally, the underwriter might have organized a corporation to undertake this work, and the corporation might cover, for varying rates of consideration, risks of loss by fire for many different types of persons and business. If the charges for such contracts were based on the average rate of loss for each class of risk, with a reasonable allowance for expense and profit, the individuals whose risks were assumed would be in the same position as under the pooling arrangement, though probably subject to a higher total cost. For them the risk would be

eliminated. The underwriter or his corporation would be subject only to the risk of minor accidental variation in the average annual loss, and to the further risk that the value of the risks assumed was underestimated. Against this would be set the chance of profit from a possible overestimate and overcharge.

Redistribution of Actual Loss.—In the last two cases, the risk has been eliminated, and a relatively small fixed charge substituted for the contingency of large loss. Something else has also taken place. The losses that have actually occurred in a haphazard way have been redistributed in an even load over those subject to the risk. This is inherent in the elimination of risk by transfer of the individual risks either to a group, as in the pool, or to a professional risk carrier, such as the underwriter. It is also a social gain. For, if the incidence of loss upon those who are not prepared for it causes them to fall into a reduced status and to render less worth-while service or (what is worse) to become community charges, a social loss results. This is true even though the aggregate loss is not reduced and is known exactly in advance, if its incidence is not known.

Insurance and Its Major Function.—The last two cases are instances of the transaction of a true insurance business: on the mutual or cooperative basis, in the case of the pool; on the proprietary basis, in the case of the individual underwriter or corporation.[1]

In the hypothetical cases cited risk has been eliminated, but not loss. *Apparently*, where the risk is covered by the underwriter or corporation, the insured has been saved from loss. In a sense this is true since, if he does sustain loss, he will be reimbursed. Yet, *actually*, if the relation is continued over a long time, he may pay for all his losses, with an added margin for the expense of conducting the insurance business. In order that the risk carriers may pay their losses and continue in business, they must collect an aggregate sum equal to the total of their losses and expenses. So far as society as a whole is concerned, there is not even an apparent elimination of loss. The physical property destroyed can be replaced only by the production of new property through the application of means of production that

[1] Further discussion of the various types of organizations for conducting the business of insurance will be reserved for Part III of this book.

otherwise might have been employed to produce other beneficial results. It is true that underwriters and insurance corporations make considerable effort to prevent loss, but the cost of this work is met from the funds collected from the public. It is also a comparatively modern development. The pure insurance activity, even though it does not eliminate or prevent loss, is beneficial to society through the elimination of risk and the redistribution of loss, and the cost of this activity is justified by the value of these services alone. It is well for the present to keep attention focused on this fact in order to appreciate fully the principal service of insurance.

Insurance and Credit.—Allusion has been made to the extent of the use of credit in modern economic life, and to the fact that risk tends to restrict credit. During the past century the use of credit has become increasingly extensive and in practically all cases where risk is present and where insurance against that risk may be had, insurance is insisted upon by the lender before credit will be extended. Recent discussion among credit officers of banks has indicated a tendency to place added emphasis on insurance even in the case of current bank credit for commercial enterprises of high credit rating.

Perhaps the place of insurance in modern economic life and its relation to credit transactions may be more clearly visualized by an analogy with certain physical conditions in transportation. Persons and property may be carried over poor roads on vehicles in which the weight-carrying body rests directly on the axles. Such vehicles are usually of the two-wheel type. In such vehicles, however, progress is slow, carrying capacity is limited, and the strain on the motive power, usually animal, is extreme. Breakdowns are frequent. Any irregularity of the roadway strikes the wheel with full violence, doing maximum damage to it, to the axle, and to the body bearing upon it. If the roadway is smooth and hard, conditions are better, but far from good. Such vehicles were used by the ancients whose commerce was almost entirely water-borne. They are sometimes used in backward regions today.

The intervention of springs brings a material change. The shock received by the wheel in passing over the bumps and hollows is now taken up by the springs and distributed over the

entire vehicle. No part receives the full force of the blow, yet all feel part of the resulting strain. Greater speed, heavier loads, greater comfort to passengers, and less strain on the motive power are now possible. The better the springs, the greater the improvement in all these respects. But, even with the best of springs, transportation over a poor roadway is not so swift or easy as over a smooth one. For effective transportation, springs are a great aid, but they do not eliminate the blows sustained from poor roads. Hence, railroads are steadily trying to improve roadbed, reduce curvature, and otherwise eliminate the conditions that make work for springs, with consequent improvement in service. Since the advent of the automobile even the best of spring makers are constant advocates of good roads.

The insurance business, in its pure insurance function (ignoring for the moment its efforts at prevention), may be likened to the springs of a vehicle. It absorbs the shock and distributes it over all risks insured in the same class. It permits a freer functioning of credit and industry generally but does not eliminate loss. The retarding effect of risk is removed, but the cost and retarding effect of loss are still present. The burden is still on society to prevent the loss. The insurance carriers can and do lend their aid by advice and in other ways, and probably can do some parts of the work better than any other agency, but the cost is charged to, and paid by, the public, and the carriers' power of accomplishment is limited by the extent of the cooperation they receive from the public.

As has already been explained, the insurance business is concerned with pure risk only. Other types of risk also create burdens for society, and it is desirable that they should be eliminated as far as possible. The principle of mass stability may be, and is, applied to this problem through the operations of speculators and other risk bearers. Were this a general treatise on risk and risk bearing it would be necessary to discuss these practices and their relation to economic well-being. This, however, would lead too far afield from the main subject, and the student interested in the wider field is referred to the general treatises on the economic theory of risk and risk bearing for an adequate discussion of these other practices.[1]

[1] See, for example, C. O. Hardy, "Risk and Risk Bearing."

Insurance vs. Gambling.—The transaction by which risk is transferred from the individual to the underwriter resembles in many respects a bet and is often referred to as such. It is said, for example, that the householder bets $20 that his house will burn within a 3-year period against the insurer's wager of $3,000 that it will not. The resemblance, when the transaction is stated in this form, cannot be denied, and it is often claimed that insurance is, in essence, gambling. It is desirable to examine this point and to establish whether the similarity between insurance and gambling is essential or merely superficial.

Gambling.—A bet on the way a coin will fall, or on the result of a horse race, will be readily recognized as gambling. Before the bet is laid, the fortune of neither of the betters can be influenced by the uncertain future event. Neither is subject to a risk on account of it. After the bet has been made, each is subject to a risk of loss—though more thought is usually given to the possible gain. By the transaction a risk was created for each. A bet at a gambling table or roulette wheel at the Casino at Monte Carlo or Deauville is made under different conditions. The gambling house is daily handling large numbers of such transactions and is subject to no appreciable risk as the law of numbers applies. The new bet merely adds one more to the number of transactions, tending thereby further to reduce the small margin of risk due to slight irregularities in the way the transactions turn out. Although this is true as to the "house," it is not true as to the man who made the bet. He was subject to no risk before he bet. The bet created the risk. An examination of any number of gambling transactions would reveal the same condition. The essence of the transaction that makes it gambling is the arbitrary[1] creation of a risk, either for the thrill it may give or because it is estimated that the chance of gain exceeds that of loss. Since risk is inimical to economic progress, gambling is antisocial. In general, in the United States, gambling contracts are not enforceable, and most forms of gambling are unlawful.

The gambling contract might be in the form of an insurance

[1] A risk is sometimes created as a necessary condition of social service, as when one builds a house and creates the risk of loss by its destruction by fire. But the creation of risk in this case was incidental and not the purpose of the action. It is, of course, not gambling.

transaction, as when one takes out a policy of fire insurance on the property of another in which one has no financial interest, or a policy of life insurance on the life of another whose death would not in any way cause one loss. There is a double reason for prohibiting such contracts; they not only create unnecessary risk, but they tempt to the crimes of murder and arson. Such life-insurance contracts were at one time permitted and enforceable in England, but recognition of their true nature and dangerous character caused them to be prohibited in the eighteenth century.

Insurance, the Reverse of Gambling.—The true insurance contract accomplishes exactly the reverse of the gambling transaction. Prior to its negotiation the individual is subject to the risk insured against. After its issuance he is not. The insurance carrier, by combining the risk assumed with that of many others, destroys it as a risk, a certainty or near certainty resulting.[1] This is a high social service, and the activities of insurance carriers are promoted and safeguarded by wise public policy.

Speculation.—Some underwriters have in the past taken risks of which too few existed to permit the operation of the law of large numbers. As an example may be cited agreements to indemnify in large amounts famous violinists for loss due to injury to fingers. It is commonly understood that there are underwriters at Lloyd's, London, who are willing to issue policies insuring against almost any type of risk, however singular or spectacular, be it only a real risk. This is spoken of popularly, often with ridicule and contempt, as being mere gambling; but according to the foregoing analysis and definition of gambling

[1] The residual risk in the mass of risks assumed and combined by insurance carriers has a value by definition equal to the probability of loss multiplied by the amount at risk. This is not the same probability as that to which the individual was subject, but the probability of a departure from the average. This varies according to the size of the departure but is much less than the original probability. It may also be a positive or negative departure and thus tends to a balance. Further, the burden of risk, as has already been indicated, is dependent, not on the absolute possible loss, but on the possible loss in proportion to resources. This again is much less in the case of a well-managed insurance carrier than of the average individual.

such practices are not properly so described. There is no creation of risk. Violinists of first rank, very clearly, are exposed to risk of very large loss from injury to their fingers. Neither does it apparently come within the definition of insurance, since the risks are too few in number for any underwriter to get a satisfactory volume to give a reasonable average, *i.e.*, to permit the operation of the law of large numbers. The qualification should be noted that underwriters covering such risks usually cover a large number of risks of varying types, though each may be unusual in itself. In such a business there is often found a stability in the mass that resembles in greater or less degree that developed from a large number of like risks, but, even though there were not this limited application of the insurance principle, the case would be quite different from the gambling transaction. It is a transfer of already existing risk, not the creation of new risk. Though no elimination of risk may take place, this transfer is not inimical to social welfare unless it is from stronger to weaker shoulders, or promotes such indifference to prevention as to increase the actual losses occurring. Usually the transfer is from the weaker to the stronger. Those assuming the risk divide it among themselves so that they are in a better position to stand it than he who was originally subject to it. Among insurance men such transactions are known as "speculative transactions" or "speculative insurance," or more briefly, "speculation." It will be apparent that there is considerable resemblance to those transactions in the commodity markets usually called "speculative." *Speculation*, when used in connection with insurance, may be defined as the transfer of risk without amalgamation and without redistribution. 'Such transactions do not perform the social service of insurance, *viz.*, the elimination of risk. The incidence of the actual losses that occur is still haphazard. The social gain, if any, is the transfer from one less able to stand the shock to one more able.

If it is not known, when a new type of risk is offered for insurance, what is likely to be the actual average value of the risk and if its probable volume at the outset is limited, the underwriting of such insurance is speculative. For example, rain insurance, *i.e.*, the insurance of the proprietors of outdoor exhibitions against loss due to untimely rain, was begun in a very tentative way.

Although, in the records of the Weather Bureau, there were data from which the risk could be estimated, the volume of insurance that could be obtained was felt to be too limited to develop average conditions. Now, with the data to estimate risk and the experience of a past volume of business to serve as a guide in other respects, it has passed from the speculative type to the true insurance type of transaction.

If, in the speculative transaction, the risk tends, after transfer, to be greater than before, the transaction tends toward gambling, and is antisocial because it imposes an additional impediment to economic advance.

SUMMARY

1. An individual enterprise subject to a very large number of similar risks may be able to apply the law of large numbers within itself, requiring no external machinery to eliminate risk. Although, with the tendency of industry to concentrate in large units, the numbers of such enterprises are increasing, they still form a small part of the whole.
2. The law of large numbers may be brought into play on behalf of those exposed to one or a small number of risks, either by cooperative effort and pooling of risk (transfer from individual to group), or by transfer to professional risk bearers, *viz.*, underwriters or insurance corporations.
3. In the process of such transfer the loss is also distributed over all subject to the risk.
4. Although the transaction of insurance has some resemblance to certain forms of gambling, it is in essence the opposite, gambling always involving the creation of risk, and insurance its elimination. Between the two are speculative transactions having closer resemblances, sometimes to the one and sometimes to the other.
5. Insurance, while eliminating risk and redistributing loss, does not, in so doing, reduce loss, and the existence of insurance does not justify inattention to prevention of loss.

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CHAPTER IV

PREVENTION OF LOSS

The cost of risk, although real, is of a secondary sort. It arises largely from the psychological effect upon human action of possibility of loss, and of uncertainty whether it will actually befall the individual. In addition to this burden, society must bear the undiminished burden of actual loss.

Prevention More Desirable than Insurance.—Even when the risk cost is eliminated by insurance, the service cost of conducting the insurance business (and this is not negligible by any means) is added to the loss. Therefore, though a particular type of loss cannot be wholly prevented, there will be social gain if it can be reduced because of the reduction of the loss and the reduction in the cost of the insurance service, which tends to increase roughly in proportion to risk. These propositions are axiomatic but they are generally overlooked or forgotten. "I am insured. I should worry!" is all too often the public attitude, and if, after reading the account of a disaster, one reads the trite falsehood, "Loss fully covered by insurance," one sinks back into a complacent satisfaction with the workings of the economic organization and passes to the next item.

American Indifference to Prevention.—This is notably an American attitude. In a country of vast resources only partly tapped, it is natural for people to try to use what they have to the utmost and rush ahead to get more, rather than "waste" precious time in the slower process of saving and trying to add a little to the accumulated store. It is, of course, true that all manufacturing consists in the destruction of certain things in order to change the form of the materials of which they are made into more useful things. Thus, coal is burned and iron ore smelted to make steel; trees are cut down and sawed up to make lumber; other materials are used to make glass. Out of these products houses are built and other useful things are made.

Our purpose would have been defeated and our advance retarded, if these processes had been interfered with or prevented.

Gain from Prevention.—There is a vast difference between this destruction of raw materials as such, and allowing the house to stand without paint until it rots away under the wear of the elements. The destruction of the raw material in the first case was not a loss but a gain, for out of the destruction came something more useful. In the second case there was real loss. As long as the cost in labor and material of safeguarding what one has is less than the cost of replacement multiplied by the probability of loss without such safeguarding or, in other words, as long as the aggregate annual cost to all individuals of prevention is less than the average aggregate loss prevented, clearly there is social gain in prevention.

The general principles of preventive and protective effort may now be considered. The practical application of these principles to each of the fields where loss may occur is an engineering problem related to that field. Discussion of such specific problems in detail will not be attempted, but an endeavor will be made to give a sufficient number of illustrations to make clear the meaning of the general principles discussed and to show the relation of the specific problems to the insurance business.

Types of Preventive and Protective Efforts.—Preventive and protective efforts fall into four classes:

1. *Truly preventive*, the purpose of which is to eliminate the causes of loss and which is usually structural in nature. In the case of physical property it is most effectively applied in the planning and construction of the house, machine, or other property.

2. *Protective* or *quasi-preventive*, the purpose of which is to protect things or persons subject to damage.

3. *Minimizing*, the purpose of which is to limit damage to as small a compass as possible.

4. *Salvaging*, the purpose of which is to preserve as much as possible of the value of damaged property.

The world not being in a series of compartments but a continuous whole, there is some overlapping of classification so that some efforts fall into two or more classes but, generally, the types may be distinguished. Each of these classes may now be

examined from the point of view of its effectiveness, its agencies, and its promotion.

True Prevention.—Preventive efforts of a fundamental or structural sort are the most effective. A fireproof house[1] cannot burn. A machine with nonremovable guards which make it impossible for a person to come in contact with moving parts cannot injure its operator. It may often be beyond the limits of practicable efforts to go so far. Much, however, may be done to prevent loss by proper structural safeguards. European cities, built largely of brick and stone, have a much lower fire-loss record than American cities. The old city of Salem, N. C. (part of the modern Winston-Salem) has had an almost perfect record, largely because it was built of brick by a Moravian community, rigidly in accordance with standards of fire protection. The city of Denver, Colo., has an enviable record owing to the absence of wooden structures. Much reduction in industrial accidents has resulted from improved machine building under the influence of the safety movement following the passage of workmen's compensation laws. Many devices are now safely used in homes, the predecessors of which in the factory were regarded as most hazardous, *e.g.*, power ironing machines and centrifugal extractors. Probably the most striking example of true preventive effort is the elimination of the yellow-fever menace in the Canal Zone and the Gulf states by mosquito control.

The beginning of such efforts must be in community sentiment, *e.g.*, a demand for an adequate building code and its enforcement. Such a code should deal with materials, design, and equipment.[2] Likewise an adequate and enforced safety law is the beginning of industrial safety in machine design. Suitable sanitary codes are an essential in the prevention of loss due to sickness. The same principle applies to all fields.

Hazards change with the progress of science and invention, and such codes, to be effective, must be kept up to date. As

[1] It is said that there can be no completely fireproof building, *i.e.*, one which cannot be damaged to any extent by fire.

[2] A model code was prepared by the National Board of Fire Underwriters in 1905. It has been revised from time to time to keep it in line with increasing knowledge of hazards and safeguards. A standing committee of the Board is charged with constant study of the subject.

legislative machinery is usually cumbersome and slow moving, some communities have passed general statutes providing for such codes and have delegated to special commissions, employing competent engineering and other assistance, the framing and correcting of the specific codes.[1] The prime essential in this respect, however, is an aroused public sentiment in favor of safe conditions and, consequently, of a good code and its enforcement. Even better is the ingrained habit of safety as with the Moravian settlers of Salem. This is not the usual heritage of our conglomerate American city populations. Of course, the code of itself is not preventive. It is construction in accordance with the code, and the efforts of individuals to surpass the code, that bring progress.

Insurance Carriers' Preventive Efforts.—Development of good practice in preventive effort depends upon knowledge of hazards gained in the past by experience and by laboratory tests. The Underwriters' Laboratories, Inc., which is sponsored and controlled by the National Board of Fire Underwriters, makes it its business to test in the laboratory fire-resisting and fire-controlling materials and devices, and the fire hazards of various processes. Devices and materials tested by it and manufactured under its specifications are permitted to carry labels certifying to their classification in accordance with such findings. More recently, the Laboratories have undertaken similar tests of machine design and safety devices. Mutual companies not affiliated with the National Board have similar laboratories, and there are several organizations in different countries of the world for inspecting and certifying ships.

If efforts along these lines are effective and the loss cost is reduced, it should be reflected in reduced insurance cost. Experience has shown that this is the case. By adjusting rates to the loss-preventive effect of structural conditions and of other true preventive effort, insurance carriers encourage better conditions and, to the extent that such adjustment is accurate, may direct effort and expenditure into the most effective channels.

Protection.—Protection is less effective than prevention and is not a substitute for it; but, if property is subject to loss,

[1] In New York, for example, the Industrial Board is charged with framing the Safety Code, and the Industrial Commissioner, with enforcing it.

protective effort is in order up to the limit of practicable cost. Protective efforts against certain types of risk are undertaken at large cost by all communities, yet, even in regard to these types, there is opportunity for the individual owner to supplement the community effort. As to other types of risk the matter rests largely with the individual. The most conspicuous protective efforts are the maintenance of police departments for protection against loss due to crime, to fire, and more recently, to vehicular traffic. Elevator and steam-boiler inspection is undertaken by the governments of most of the states, though the inspection of authorized insurance companies is usually accepted in lieu of such public inspection. The purpose of inspection is to see that conditions are not present which are likely to cause loss.[1] Safety inspection of factories is undertaken both by the state and the insurance companies, with a view to eliminating causes of loss due to weakened structural conditions or substandard conditions in buildings and equipment, or to hazardous processes and unsafe practice. This is true preventive work, but it takes on also the character of protective work, since it results, when structural conditions cannot be changed, in the requirement of protective measures. Periodic watchman service, especially if checked with a recording clock, is a safeguard against loss by theft, fire, and other causes, such as water leakage. These latter efforts, however, partake also of the nature of the third class. One of the most potent efforts in the protective class is the campaign of education in "safety first" applicable to all types of risk, tending as it does to the discovery of weak points before they give way. As before, a suitable allowance in the insurance rate for the effect of these efforts tends

[1] It is often contended that insurance of steam boilers, a few other similar types of insurance, and surety bonding are not in essence insurance because their major purpose is prevention. It is to be said in favor of this argument that, in these lines, the effort is not to measure the risk but to charge a fee for inspection and selection service with a margin for the undiscovered risk. This margin is not fixed, however, and there is a certain measuring of residual risk in determining it for various classes of risks. In most lines of insurance it is not feasible to go so far, though all carriers have so-called "prohibited lists" of types of risk which they will not accept, and some carriers require risks to meet certain standards of prevention and protection before they will cover them.

to stimulate them and turn them into the most productive channels. This allowance is only equitable since, if the function of insurance is to combine risks and distribute the loss of the mass over the individuals, each individual should be charged only in the proportion that he tends to contribute to such loss. In certain European cities the citizen on whose premises a fire originates is held liable to the city for the cost of calling out its fire fighters, and to his neighbors for damage to their property unless he can prove the fire was unpreventable.[1]

Efforts to Minimize Loss.—Probably more community effort and money are expended in seeking to minimize loss than in any other direction. For under this head falls the maintenance of fire departments, of water supplies for fire fighting, and of other emergency equipment and organizations. Such efforts are necessary, but a much smaller fire department can effectively serve a city in which frame exteriors and shingle roofs do not exist than one where the major part of the construction is of that type. A much smaller expenditure is required for medical service when water and milk are properly inspected and safeguarded against infection than when such work is not done. It has been found much more effective in military organizations to inoculate against typhoid fever and similar causes of disability than to rely entirely on hospital facilities and quarantine for those who may become infected. Efforts to minimize loss are not to be neglected, but the need of such efforts will be much reduced by effective measures for prevention and protection.

Probably no device for minimizing loss is more important than the automatic sprinkler system now so widely used in manufacturing and mercantile establishments as a protection against fire. These systems consist of overhead water piping with valves spaced at about 8-foot intervals. The valves are kept closed by a lever held in place by fusible material and are faced by a small baffle plate. When opened they throw a spray over a circle about 8 feet in diameter. Excessive heat will

[1] It is a long-standing rule of the law of this country that one must respond in damages for the consequences of negligent actions. Technical defenses as well as insurance against judgments on account of such neglect have, however, lessened the fear of consequences so that the preventive value of the rule is somewhat doubtful.

release the lever and open the valve, usually extinguishing the incipient blaze or at least holding it in check until the arrival of the firemen. A thermostatic alarm is usually coupled with the system to call the fire department or a watchman for, if this were not done, in many cases the water damage might exceed the fire damage.

Salvage.—Salvage operations are profitable if the salvaged property represents a value greater than their cost. Whatever net recovery is had by salvage operation on insured property directly reduces the loss to be paid by the underwriters. Salvage operations are conducted by underwriters in many lines of insurance, notably by marine underwriters in connection with the recovery of ships and cargo. Salvage operations are seldom conducted by community efforts, though the police recover much stolen loot, and fire departments and coast-guard corps endeavor at great cost to save lives threatened in burning buildings and marine disasters.

Fighting fire involves more or less water damage to goods, even if they are not directly damaged by fire. Underwriters in nearly all communities of any size have organized Underwriters' Fire Patrols which respond to fire alarms, spread waterproof coverings over goods, and otherwise prevent further loss. Such patrols are given the same right of way on the streets as the fire department apparatus. In some cases they are maintained by voluntary organizations of fire-insurance carriers; in others, all fire-insurance carriers are required by law to contribute to their maintenance. Superficially, such efforts seem to be purely selfish since they are concerned only with the reduction of the loss to be paid by the company. But, in the long run, because of competition or state regulation of rates, or often of both, the rates charged the public will equal the net loss plus the cost of doing business. In any event, the preservation of property is a community gain.

Another type of salvage operation, frequently carried on by special organizations is the reconditioning for sale of smoke- and water-damaged goods.

Similar in nature and result are the rehabilitation efforts made by insurance carriers and others in behalf of workers injured in the course of their employment and entitled to benefits under workmen's compensation acts. Insurance carriers are

prompted to offer such claimants the best type of rehabilitation treatment because it will reduce the cost of the compensation they are required to pay. But the victims of industrial accidents and the community profit much more than the insurance carriers by their restoration to earning power.

Salvage operations, however, are but a negative sort of preventive effort. Far more importance must be attached to positive efforts of prevention and protection.

Insurance Carriers and Prevention.—To solve the problem of fixing a proper rate for each risk presented for insurance, underwriters must study hazards and the relative effectiveness of means of reducing them. Naturally, they have come to be looked upon as experts and leaders of the community in prevention. It is to be said, with regret, however, that until comparatively recently the underwriters had not fully realized and responded to their high opportunities. As early as 1764 the underwriters at Lloyd's, London, had compiled and issued for their own use "books" (the precursors of the modern shipping registers) expressing their opinion of the hazard value of existing shipping. These were carefully guarded by their owners, however, and there appears to have been no effort to improve shipping or shipbuilding.

The first efforts at prevention or protection by the insurance business, of which we have records, were made by the first joint-stock and mutual fire-insurance companies formed in London after the great fire of 1666. Since, with fixed premiums, whatever salvage was made went to the profits of the companies, their managers early saw the value of salvage efforts. These companies organized and maintained uniformed private companies of fire fighters, and equipped them with such simple devices as were available in that day. The companies also devised markers or house plates to identify the houses insured by them. When not engaged in putting out a fire in an insured house or in salvaging the contents, the firemen were free. It is said that often, on observing a fire, they would run to the house and; if they found it was not insured by the company by which they were employed, they would bargain with the owner for the best reward he would pay for their aid. House plates and private fire brigades were also used in earlier days in the United States.

These efforts, it will be recognized, were only of the socially less profitable classes, though there is record of a company in Philadelphia which, in colonial days, declined to insure houses with trees in front of them because trees were found in some instances to have handicapped the efforts of fire fighters. This was a crude and probably ill-judged effort at improvement of the risk, but it can hardly be classed as truly preventive.

In the early part of the last century, the attitude of insurance company executives was that it was their business only to measure hazards and collect premiums to cover losses. It was the owner's duty to attempt prevention. Thus, when the owner of a textile mill in Providence, R. I., sought advice on preventive measures, he was rebuffed. This lack of interest on the part of the established companies, together with their unwillingness to cover certain parts of the mills, and their crude rating system which did not allow credit for protective efforts, led to the formation of mutual companies among the mill owners for insuring their premises and specializing in preventive efforts. The severe competition so developed opened the eyes of company executives to the error of this policy, and their attitude has since completely changed. In view of the slowness of the business world as a whole to abandon the theory of trade secrets as against high public service as a means of trying for competitive advantage, this attitude is understandable.

Fire and Marine Insurance.—In the present day, the leaders in preventive effort in all lines are the insurance carriers. The knowledge acquired in investigating losses and their causes equips them to be leaders in such work. In fact, they have gone much further and have promoted research to develop new standards and better practice. Lloyd's and the various organizations of marine underwriters in different countries have representatives in the leading shipbuilding centers and world ports for the supervision of construction and repair of ships. They have developed most efficient marine intelligence offices and have been instrumental in the passage of legislation for proper loading limits and other safeguards. Among the primary functions of the National Board of Fire Underwriters are the prevention of arson and the development of fire prevention and protection. Attention has already been called to the Board's

development of an ideal city building code, and its operation of the Underwriters' Laboratories. Of great significance is the work of the Board's engineers in surveying and grading the towns and cities of the United States from the point of view of their fire hazards and protection against them, including, among other things, water supply, building construction, street arrangement, and fire and police departments. Although these investigations form the basis for establishing insurance rates, recommendations for improvements are also embodied in such reports.

Reformation from without is always difficult and distasteful. The most effective work must be by education so that the desire comes from the public. The National Board has, therefore, encouraged in every way the work of the National Fire Protection Association, which is composed of public officials and others interested in the prevention and control of fires, and is organized for the purpose of furthering such work.

Life Insurance.—The life-insurance companies have not, until within the twentieth century, realized the opportunities which lie before them for life conservation. At the present time, the more progressive companies are active in this work in two ways: first, they have incorporated in their policies (for appropriate premiums) clauses granting certain benefits in event of total disability of considerable duration which tend to life conservation by relieving many invalids of financial worries and by enabling them properly to care for themselves, often resulting in the checking of diseases like tuberculosis;[1] second, they are freely furnishing statistical data to those interested in public health work. Some of the companies insuring for small sums the members of the industrial classes also furnish a free visiting-nurse service.

Workmen's Compensation Insurance.—With the adoption of workmen's compensation laws, which specify benefits and make rates for the required insurance subject to state regulation, insurance competition in this field has centered in no small degree upon service to the insured employer. Rate reductions can be brought about only by reduction in hazard, and definite

[1] The interpretations given these clauses and the tendency to claim benefits under conditions not anticipated by the companies have resulted in a radical curtailment of the benefits.

schedules, allowing rate reductions for better than average conditions and requiring penalties for poorer conditions, are in use in some states.[1] Insurance rates also are modified in accordance with the losses experienced on individual risks. Although inspections are made by central rating offices for the application of these schedules, the carriers very jealously reserve to themselves the right to make safety recommendations for plant improvements; and they vie with each other in the services they offer.

The insurance carriers liberally support the National Safety Council, an independent body for the promotion of safety in factory operations and in life in general, as well as other safety organizations. Special advice in safe practice and inspection to find where improvements can be made, with proper rate concession for the improvements, are offered by the carriers of many types of insurance.

The loss statistics of insurance carriers furnish essential information on hazards. But, as has been well said by the late Edward Atkinson, President of the Boston Manufacturers Mutual Fire Insurance Company, a recognized authority on protection and prevention, "The only persons who can prevent loss by fire are the owners and occupants of the insured premises." The same principle applies equally to other hazards. It has been said that the best safety device is a careful man. The insurance carriers show where efforts should be especially concentrated; they show what is best practice in safeguarding at that point; they offer suitable concessions from the average rates for superior, and impose penalties for inferior, conditions or even refuse coverage if conditions are too bad. Thus they appeal to the pocketbook, which is said to be the strongest appeal. Beyond this they cannot go. Thenceforward, prevention is a matter for the individual and the community.

Insurance as a Cause of Loss.—In one respect, the existence of insurance militates against safety: when full, or nearly full, insurance leads to a spirit of recklessness and develops the hazard

[1] Schedule rating was formerly in general use, but has been abandoned in several states because general improvement has been reflected in basic rates, and the slight differences in rates were thought not to justify the expense. Experience rating is now generally applied.

of a broken morale, or, when overinsurance leads to a true moral hazard. The carriers have sometimes been criticized for negligence in permitting overinsurance, particularly in the case of small amounts of fire insurance on household goods. One flamboyant exhibit was arranged by a fire department which had comissioned a man to seek insurance on household furniture at various locations in the city far in excess of the property on the premises. A hall was then rented, and in separate booths constructed about the walls were shown the few poor articles of furniture which had been in each of the premises, the insurance policy obtained being displayed beside them. It was intended to substantiate the charge that neglect to inspect the furniture had made overinsurance possible and that, therefore, the over-insured were tempted to arson. That the temptation would be presented by such conditions can hardly be denied, but the degree of temptation is not so great as appears at first glance, for the insured know that their claims will be carefully scrutinized and that in an apartment or tenement building, total destruction that would conceal the fraud would be unlikely. Before the carriers are condemned on these charges, consideration should be given to the expense involved in complete inspection of every such risk, and to the probable ineffectiveness of such inspection in view of the movable character of the property.

That not only fire losses but losses from most hazards exceed what they should be must be admitted. That a certain amount of such loss is due to effort to perpetrate fraud on insurance carriers cannot be denied, but the proportion is probably relatively small. Neither can it be denied that the existence of insurance and certain insurance practices may have caused in some cases an increase in hazard. But the major cause is to be found in public apathy.

SUMMARY

1. Loss prevention is greater in its potentialities for public service than risk elimination, and has four phases:

a. True prevention (usually structural).

b. Protection.

c. Minimizing of loss.

d. Salvage.

2. Insurance carriers have unusual opportunities for determining the most effective measures in each of these lines and, in recent years, they have used them to develop information and make it available to the public. They have, where possible, added inducements of a pecuniary nature for such measures and have, of their own initiative and at their own expense, maintained the means for salvage.

3. It is unfortunate that the public is apathetic toward the problem of fire and other losses, but there are signs of an awakening of the public conscience in this regard.

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Part II

INSURANCE CONTRACTS

INTRODUCTION TO PART II

To most people, insurance policies are everyday affairs. They are taken as a matter of course. Few businessmen read them. Still fewer understand them. When they find the obligation of the insurer not so full as they believed it to be, there is a tendency to assume wrongdoing on the part of the insurer and, in righteous indignation, to rush to the legislature for remedy.

Much of this irritation would be avoided if there were a clearer understanding of insurance contracts. They are not difficult of comprehension if carefully and systematically studied. It is the aim of the following chapters to give such a comprehension by pursuing a systematic plan of analysis. A foundation has been laid in Part I, in which was developed the concept of the insurance contract as the means through which risks are transferred and eliminated.

Chapter V will be devoted to general considerations, and the remaining chapters to the contracts used to cover the more important types of hazard.

CHAPTER V

FUNDAMENTALS OF INSURANCE CONTRACTS

By tradition, first, and later by statutory enactments, the business of assuming pure risks for the purpose of neutralizing and eliminating them has come to be divided into several branches, according to the type of risk dealt with. Since the contract of insurance must do three things clearly: first, define the risk transferred, second, state the conditions under which the contract applies, and, third, make plain the procedure of settling

the loss that may occur, the forms of contracts used in the several branches differ in a greater or lesser degree. It will, therefore, be necessary to consider the peculiarities of each major type of insurance. Fundamentally, the aim is always the same, and there are broad underlying principles which apply to all branches. It is the purpose of this chapter to discuss these common fundamentals.

Only Financial Risk May Be Transferred.—If A is owner of a property and is subject to risk from its possible loss and the risk is to be transferred to B, then, upon the transfer, if it is to be complete, A must be free of all risk in the matter and B must be subject to the same risk to which A was previously subject. In Part I, it has been tacitly assumed that this was generally possible, but it is necessary to impose limitations. A few examples will clear up the matter: Let the property be a house. A might sell the house to B. Then, A would be free from the risk of the house's destruction, and B subject to it. A might enter into a contract with B that, if the house burns, B would rebuild it. The transfer is not quite so complete here. For, although A would have a new house, he would have to wait until B could build it and, although B would have to build a house, he would have none of the other inconvenience A would have. A might contract with B to furnish the funds for rebuilding instead of to rebuild. This would leave him perhaps in a better, and perhaps in a worse, position than before, depending on whether he would prefer the new house or ready cash. B would be relieved of the responsibility of having the house built.

Suppose it was an original Corot that A possessed. Could he transfer the risk? By a sale, yes. He could not contract to have it replaced because it could not be replaced. He could contract for the payment of an indemnity equal to its value. B would then have a risk of loss of the value. A would still have the risk of the physical loss of the picture but would have it replaced by a value by means of which he might obtain equal pleasure and benefit. A would not have transferred to B his precise risk.

Suppose that, instead of a house or a Corot, the property that might be burned was a crude table, fashioned by the hand of a boy, his son, who, in his early manhood, had been killed in war. The father cannot place a value upon it, so precious does it seem.

He could not sell it for a dime, for to another its value is only kindling. Can he transfer his risk of loss? How? There is no contract the mind of man can devise that would take the risk of that loss from A and transfer it to B.

It is apparent then that it is impossible to transfer every risk. Risks of loss of sentimental values cannot be transferred. Risk of loss of unique physical values can be transferred by sale of the object, but not without parting with the ownership which makes loss, and hence risk, possible. It cannot be transferred by a contract of replacement of any kind.

Risk of loss of the market or replacement (cash) value of anything may readily be transferred, for such value is expressed in, and represented by, the medium of exchange.

It is with the latter risk—of loss of cash value—and with this risk alone that insurance deals or attempts to deal.[1]

Form of the Insurance Contract.—Stripped of all the verbiage involved in designating the risk, and in defining how loss shall be proved and collected, and reduced to its simplest terms, the insurance contract is a promise of one party (the *insurer*) that, in consideration of the payment, or the promise of payment, of a sum of money (the *premium*)[2] by the other party (the *insured*), the first party will, in case the risk eventuates in loss of a cash value, pay to the other party that cash value, usually up to an agreed maximum limit.[3] This is clearly a transfer of the risk of cash-value loss from the one party to the other. Assuming the maximum was not set at too low a figure, A would be free from financial risk, and B would have assumed A's financial risk.

[1] An apparent exception is life insurance, since it is often assumed that a human life cannot have a cash value placed upon it. It will be noted, however, that the insurance gives a cash benefit only on failure of the life as though that were its cash value. This matter will be discussed more fully in Chap. X. Sometimes, when insurance carriers are convinced that moral hazard is not present, they will insure property of unique or sentimental value for an agreed sum. Thus a quasi-market or cash-value risk is transferred though, as must be apparent on reflection, the risk of loss of the sentimental value is untouched, for it is intangible. That can't be [illegible]

[2] There are usually also other considerations in the nature of representations and agreed conditions. See pp. 52 and 56.

[3] Certain types of contracts provide for the rendering of services rather than the payment of money, but this is not different in principle since they are the equivalent of the cash value of the expense loss of the insured.

The remainder of the contract defines the risk transferred, states the conditions of its transference, determines how a loss shall be proved, and how it shall be paid. Though the latter points may be of large importance in a practical case, in considering the fundamental character of the contract they are merely ancillary and incidental. The essence is the evidence of transfer of risk and definition of the risk transferred.

A Contract of Indemnity.—If the essential purpose of the contract is to relieve the insured (A) from risk by transferring it to another (B) and if the form of the contract is a promise of B to pay A when the loss occurs, it is apparent that the contract is one of indemnity, and indemnity only. A is to be paid only in event of loss. He should be paid only the cash value of his loss. If he is to be paid more than the cash value of his loss, something more has been done by the contract than merely to transfer A's risk to B. A is offered not only freedom from risk but the chance of profit. Where, before the contract was entered into, he was subject to a risk of loss, he now has no risk of loss but a chance of gain.

It has already been noted that, whatever may be the condition after a loss, for example by fire, of the owner by reason of his insurance contract, society is poorer by the loss of physical wealth. Clearly, if A is to gain by destruction of his property, by reason of his insurance contract, he will be under constant temptation to destroy it, to commit an antisocial act. From this it may be concluded that considerations of public policy also dictate that the insurance contract must be strictly a contract of indemnity. It is a well-settled principle of law that the insurance contract is a contract of indemnity and indemnity only.

Valued Polices.—There are, however, certain apparent exceptions to this principle, at least one of which is very old. It is a long-established custom in marine insurance to name in the policy the value of the property insured and to pay this value in event of total loss. The insurance carrier will not be heard to claim a value less than that agreed upon. Such a policy is a *valued policy*. Were property often overvalued in such a policy, serious evils might result. Fortunately such has not often been the case, though the opportunity exists. The principle of indemnity is, however, controlling in insurance law and,

if it can be shown that the overvaluation was gross and intentional, such as to make the contract essentially a wager, the contract is unenforceable. The custom was, at the time it was first adopted, and still is, of importance as an aid to fair and proper claim settlements.

The practice of marine insurance began before the days of steamers, or even of regular lines of carriers and long before telegraphic and other means of rapid communication. Hence it might be months after a loss occurred before it was known, especially if the vessel foundered. Sometimes the precise date of loss could not be fixed. The value of goods varies from time to time, as well as from place to place. If the date of loss could not be fixed, how could the value be fixed? Since goods are shipped to places where they are expected to be more valuable than at the point of shipment, clearly the value at the point and time of departure might be presumed to be too low. Evidently much controversy may be saved if a basis value on which to adjust the loss can be fixed in advance. So long as the value is not excessive, this act of convenience does not violate the principle that the contract is one of the indemnity only.[1]

Life-insurance contracts are written for a fixed amount and the weekly indemnity under disability policies is also a fixed amount. But who can fix a money value on a human life? As most men do not insure their lives for more than a small fraction of the present value of their future expected earnings, the chance that the amount received by the beneficiary would exceed the loss is remote.

The case of the accident policy is not so plain, but great care is exercised by insurance carriers to see that the total indemnities promised in all insurance carried do not exceed the value of the insured's time.

Some states prescribe by law that, in the event of total destruction of property by fire, the insurers must pay the face amount (maximum limit) of their policies regardless of the value of the property. Such *valued-policy laws* are based on the mistaken

[1] It is also to be noted that usually the goods are not in the control of the insured or his agent during the course of the voyage, and this fact reduces the moral hazard that might arise under a valued policy covering goods on land when their actual value decreased.

theory that as the insured has paid for so much insurance he should have it. Fortunately few states now have such laws. Where such laws are in force, the contract cannot be said to be strictly a contract of indemnity. In general, it is not good public policy to permit valued policies covering property risks, except in marine insurance or in the insurance of unique values, such as art objects and manuscripts.

Insurable Interest Required.—The principle that the insurance contract is strictly one of indemnity has other implications. One of these relates to the right to take insurance. It has been intimated that negotiating an insurance contract where one is subject to no risk is not really taking insurance, but gambling. Only those subject to risk should be permitted to take out a valid policy. Being subject to risk implies that their relation to, or interest in, the property is such that the destruction of the property would result in injury to them. Such an interest is an *insurable interest*, and an insured must have an insurable interest if the policy is to be valid.[1] If an insurable interest is not present, the contract is invalid; it is a gambling contract.[2]

Examples of Insurable Interest.—Obviously, the possessor of a sole and unconditional ownership of property has an insurable interest in that property; this is the simplest type of insurable interest. But it is far from being the only insurable interest. A mortgagee to whom the property is mortgaged as security has an insurable interest to the extent of the mortgage debt. A lessee required by his lease to surrender the property in as good condition as he received it (without exemption of fire damage) has an insurable interest. Independent of any requirement of maintenance, a lessee has an insurable interest up to the value of his lease, whether due to value of established location, rent lower than current market rate, or other cause. An interest need not be in actual existence to be insurable. It may be inchoate if founded on an existing interest. For example, in the case of

[1] "Every interest in property, or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly damnify the insured, is an insurable interest." Insurance Code of California, Sec. 281.

[2] "If the insured has no insurable interest, the contract is void." Insurance Code of California, Sec. 280.

property left in trust for a life tenant, not only has the remainderman an insurable interest, but a beneficiary under his will would have such an interest if the will were actually executed. A mere expectation is not a sufficient basis for an insurable interest. For example, a kinsman of the remainderman, even though promised that he will be remembered in his will has not such an interest.

An individual always has an insurable interest in his own life and may name any beneficiary he chooses.[1] But there are insurable interests in lives, as in property, which will justify the taking out of insurance by one other than the insured. A wife, for example, has an insurable interest in her husband's life. During his presidency, a corporation has an insurable interest in the life of its president. It could hardly have such an interest in the life of an office boy, but probably would have in that of a chief engineer during the term of his contract, for his death might cause loss to the corporation.

Subrogation.—It is a well-established principle of common law that, if one person so negligently conducts his own affairs that another is thereby injured, either in his person or property, the injured party may claim indemnification from the negligent wrongdoer. If the injured person has insurance against the type of loss so caused, he may accept the indemnity from his insurer without prosecuting the negligent wrongdoer. Such action would, in a sense, be contrary to public policy, since it would encourage negligence. It is also contrary to one's sense of justice and equity to permit the injured to recover his loss from two parties, for he would profit by a community loss. His insurance contract would be the source of his profit. Hence there has arisen the doctrine of *subrogation*, which is of general application in insurance[2] and generally provided for by specific clauses in the policy contract.

Under the doctrine of subrogation, the insurer, having paid

[1] As will appear more fully in the later discussion of underwriting, there are certain conditions when the taking of the policy by the insured is really on behalf of another lacking insurable interest, and such policies should not be issued. In some jurisdictions they are illegal.

[2] The doctrine does not apply to life or disability insurance, since it is intended only to prevent such double recovery as would constitute profit, and it is generally held that there is no possible measure of the value of human life and hence no possible overrecovery or profit.

the claim, is entitled, to the extent of such payment, to receive from the insured an assignment of his claim against the tort-feasor. Recovery in excess of the amount paid under the policy must be paid to the insured, though the insured may be charged his share of the reasonable expense incurred in collecting.

For example, the workmen's compensation laws of most states provide that, if there is a third party responsible for an employee's injuries (assume he is run down by an auto truck on the street while on his employer's business), he may elect to sue for damages and that, if he recovers damages, he has no claim under the compensation law. Or, he may take the benefit under the compensation law, but, if he does so, he must assign to his employer's insurer his right of action. If the insurer prosecutes that right and recovers more than the benefit he paid, he must pay the excess to the injured worker.[1]

If the compensation benefit in the case supposed amounted in the aggregate to $1,500 and the company prosecuted a claim under its subrogation assignment against the truck owner for damages and recovered $3,000 at an expense for legal fees and court proceedings of $500, it would retain $2,000 to reimburse itself for what it had paid in compensation and expense and pay the remainder ($1,000) to the injured. If the entire compensation benefit had not been paid by the time the judgment was received, it would be entitled to retain only the discounted present value of the future installments of compensation, plus what it had already paid and its legal expense, and would pay the injured somewhat more than $1,000. Perhaps the industrial commission[2] would sanction a lump-sum settlement to close the case. Then the company would retain only an amount equal to what it had already paid plus $500 for its expenses and pay the remainder to the injured employee. If the company did not recover, net of expenses, as much as the compensation benefit it must pay the injured, it would pay him only his compensation benefit and nothing additional as the result of the claim against the truck owner.

[1] See Workmen's Compensation Law of New York, Sec. 29; and California Workmen's Compensation, Insurance and Safety Act, Secs. 26 and 30*f*.

[2] See Chap. XIII for discussion of workmen's compensation benefits and administration.

Under the compensation law of New York and of some other states the injured employee or his dependents electing to sue a third party may preserve the right to compensation by proper notice to his employer and the industrial commission. If the net recovery from the third party is less than the compensation benefit, claim may then be made for the difference, and the insurer will be required to meet it.

It was alleged that the conflagration in Berkeley, Calif., in September, 1923, was caused by the falling, during a high wind, of a negligently fastened highly charged power wire of an electric-power company into dry grass just outside the city. The insurance companies, having paid the claims of their policy-holders, demanded and received assignment of their rights, *pro tanto*, and sued the electric company. The attorneys for the companies notified the citizens of their willingness, on a specified fee basis, also to represent them in the effort to recover their uninsured excess losses.[1]

Apportionment of Loss.—It is always possible that when a loss occurs there may be more than one policy covering it. If the insured is to recover no more than his loss, some way must be found to determine the respective liability of the several insurers. In the United States this contingency is usually provided for in the terms of the policy.[2] With the exception of marine insurance, where a different rule is provided, the usual policy provision is that each insurer is liable for its prorata share of the loss in accordance with the respective amounts of the policies. If two or more policies cover the loss but are not identical in their terms, there may be a partial overlap. Such situations have led to much litigation, particularly in the field of fire insurance, and to several different rules of apportionment, a discussion of which at this point would lead too far afield. Sometimes the same loss might be covered by two policies in different fields, *e.g.*, breakage of glass due to windstorm under a glass-insurance policy and a windstorm-insurance policy. Underwriters have foreseen this

[1] The power company carried catastrophe insurance and it compromised with the insurance companies for 10 per cent of the amount sued for.

[2] In the British marine-insurance contract there is no provision, and the insured may claim under any of his policies. The law provides for proper adjustment between the insurers.

possibility and have provided for it in the phraseology of their prorata clauses.

For reasons set forth in Chaps. X and XI, such provisions are not found in life-insurance policies and are relatively infrequent in disability policies.

A Personal Contract.—In the discussion of the general subject of risk it was noted that the degree of risk is, in part at least, dependent upon the care and protection given by the owner to the property in respect of which the risk arises. Hence, the character of the insured is an important factor in determining both the willingness of the carrier to assume the risk and the consideration for assuming it. Though the insurance contract is often concerned with property that may be transferred, it is a personal contract and cannot be transferred to a new owner without the consent of the carrier. The ceasing of the insured's interest in the property terminates the policy, unless it is transferred with such consent, and the insured may claim such adjustment of the consideration for the contract as is provided by its terms.[1]

Insurance Subject to General Law of Contracts.—The insurance contract must conform to the general rules of law relating to contracts, as well as to those special rules of law applicable to insurance only, whether developed through judicial decisions or by statutory enactment relating to insurance.

The most important general rules are

1. There must be an agreement based upon an offer made by one party and an acceptance of that offer in the same terms by another party.
2. The contract must be legal in form.
3. It must be for a lawful purpose.
4. To be legally enforceable it must be based upon a valuable consideration.
5. The parties must be legally capable of contracting.
6. There must be an equality of knowledge of all material and relevant facts.

The first three of these requirements do not require discussion at this point. The several states have enacted statutes laying down the conditions with which those desiring to conduct an

[1] For reasons that will be apparent on reading Chaps. VII and X, this principle does not apply to life- and marine-insurance contracts.

insurance business must comply. These will be examined in considerable detail in Part V of this book. The theory of insurable interest, which determines the capability of the insured to make such a contract, has already been discussed. The monetary consideration for an insurance contract is either a sum paid down by the insured, or the insured's promise to pay a designated sum at a specified future time, or a combination of both. It is known as the "premium," and its fixed, or semi-fixed, character is what gives the insured the certain "loss" which replaces his risk. Usually, as a precaution for the insurer, the representations and conditions on which the contract is based are also referred to as a part of the consideration.

The requirement of equality of knowledge is of highest importance in relation to the insurance contract. In order to give full weight to its importance it is desirable, first, to consider briefly the conditions under which insurance law developed. As this will lead into the field of special insurance law, there should be noted, before passing to that discussion, a general principle relating to the construction of contracts which has had great importance in its application to the insurance contract: in case of ambiguity and doubt, a contract is to be strictly constructed against those who drew it and liberally in favor of the other party to it.

This rule does not apply to contracts in the drafting of which both parties took part and which are signed by both, but only to contracts which are drawn by one party and which must be accepted or rejected by the other party without alteration. This is usually the case with insurance contracts. Nor does the rule mean that the insured, by merely alleging ambiguity and giving his interpretation, may have that interpretation. The court must first consider the disputed language, using the test of the reading by a reasonably prudent man and the common understanding of the meaning of the words used, and decide whether there is a real ambiguity. If it finds the language is in fact ambiguous, it must then consider what would be the interpretation that a reasonably prudent man would give it, disregarding any specialized meaning that the drawer might contend he intended it should have. If the insured's contention met this test, his claim would be recognized. But even in the

case of ambiguity he would not be permitted a forced and unusual interpretation in his favor. The rule is not intended to give any special advantage to the accepter of the contract but only to deprive the drawer of such special advantage as his position as the draftsman might give him.

Development of Insurance Law.—The insurance of ships and cargoes—marine insurance—the earliest form to be practiced, had become well established among the London merchants by the time of Queen Elizabeth. Questions relating to it were settled in the merchants courts, which they had established among themselves for determining their disputes in accordance with established mercantile custom. The general principles of insurance law were established in considering transfers of marine risks at a time before any of the modern means of communication—telegraph, telephone, submarine cable, radio, regular steamship lines—had been invented. Unless he received his information by chance, the insurer rarely had any basis for judging the risk he was asked to assume other than the information furnished by the insured. Vessels about to sail could be inspected, but this was not possible if a vessel was on the other side of the Atlantic or at any foreign port, and the insurance was desired for the return voyage. Since, in general, the insurer had to rely upon the insured for his knowledge of the risk, the business of insuring could not have developed unless the utmost good faith had been shown in describing the risk. The insurance contract came to be held, in law, one of the utmost good faith—in law Latin a contract *uberrimae fidei*—and the doctrines of concealment, representation, and warranty were developed.

Concealment.—The nature of concealment and its effect upon an insurance contract may probably be best exhibited by the following provisions of the Civil Code of California[1] which attempts to set forth in brief form the *accepted maxims of the common law:*

SEC. 2561.—A neglect to communicate that which a party knows, and ought to communicate, is called a concealment.

SEC. 2562.—A concealment, whether intentional or unintentional, entitles the injured party to rescind a contract of insurance.

placed in 1935 by Secs. 330 to 339 of the Insurance Code.

Sec. 2563.—Each party to a contract of insurance must communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract, and which the other has not the means of ascertaining, and as to which he makes no warranty.

Sec. 2564.—Neither party to a contract of insurance is bound to communicate information of the matters following, except in answer to the inquiries of the other:

1. Those which the other knows;
2. Those which, in the exercise of ordinary care, the other ought to know, and of which the former has no reason to suppose him ignorant;
3. Those of which the other waives communication;
4. Those which prove or tend to prove the existence of a risk excluded by a warranty, and which are not otherwise material;
5. Those which relate to a risk, excepted from the policy, and which are not otherwise material.

Sec. 2565.—Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries.

Sec. 2566.—Each party to a contract of insurance is bound to know all the general causes which are open to his inquiry, equally with that of the other, and which may affect either the political or material perils contemplated; and all general usage of the trade.

Sec. 2567.—The right to information of material facts may be waived, either by the terms of insurance or by neglect to make inquiries as to such facts, where they are distinctly implied in other facts of which information is communicated.

Sec. 2568.—Information of the nature or amount of the interest of one insured need not be communicated unless in answer to an inquiry, except as provided by Sec. 2587.[1]

Sec. 2569.—An intentional and fraudulent omission, on the part of one insured, to communicate information of matters proving or tending to prove the falsity of a warranty, entitles the insurer to rescind.

Sec. 2570.—Neither party to a contract of insurance is bound to communicate, even upon inquiry, information of his own judgment upon the matters in question.[2]

[1] Sec. 2587 requires that the policy specify the interest of the insured in property insured, if he is not the absolute owner thereof.

[2] The term "judgment" in Sec. 2570 means opinion as contrasted with known facts.

Representations and Warranties.—The information communicated by the prospective insured may relate to present, past, or future conditions. As to the past or present, it may relate to facts or beliefs. As to the future, it can only be promissory.

The communication may take either of two forms: (1) *representation* or (2) *warranty*. If the subject matter concerned is clearly material to the contract, it makes no difference in which form it is communicated. Its falsity will vitiate the contract. Often, however, it is open to dispute whether certain data are, or are not, material. To avoid such disputes, the form of communication known as "warranty" was devised. Under this form the insured bars himself from raising the issue of materiality. If he warrants that certain things are so or will be so, the warranty must be literally true as to the past, and strictly complied with if relating to the future. The latter type is a *promissory warranty*. Hence, any falsity in a warranty entitles the insurer to avoid the contract, whether or not the warranty relates to a thing that is material to the contract.

The student will perhaps get a clearer impression of the significance of warranties if he will substitute for the word "warrants" in the above paragraph the more popular modern term for the same act, "guarantees." As with modern practice in many fields of insurance, negotiations for the early marine-insurance contracts, actions upon which gave rise to insurance law, were oral. When the underwriters insisted on conditions relating to the risk which they were asked to assume and of which the applicant did not have and perhaps could not have precise knowledge, before they would undertake the contract, it was customary to note the condition, preceded by the word "warranted," and in marine insurance the practice is still followed.[1] In other forms of contracts absolute conditions have been inserted without specifically designating them as warranted. For example, the California Standard Form Fire Insurance Policy, required by legislation enacted in 1909 and still in effect, prescribes that "Unless otherwise provided by agreement endorsed hereon or

[1] See, for example, several such provisions in the form of the marine-insurance policy shown in Appendix XIV. and the "Free-of-particular-average" clauses in Appendices XV and XVI.

added hereto, this entire policy shall be void . . . (e) if this policy be assigned before a loss." Such provisions are also called "warranties." One eminent writer on insurance law defines a warranty thus:

A warranty, in insurance law, is a clause in the insurance contract that prescribes a condition of the insurer's promise, a condition, viewed as of the time when the contract is made, such that the nonexistence of the condition is a potential cause of the insured event or of increased loss resulting therefrom.[1]

In order to rescind his contract on the basis of a representation, however, the insurer has to prove both that it was false and that it was material. It need not relate to a cause of the loss but must be such that, if the truth had been told the insurer would not have made the contract on the terms on which it was made.[2]

The law with respect to representations and their effect is shown by the following provisions of the Civil Code of California[3] which similar to those relating to concealment are merely a restatement of the *general common law:*

SEC. 2571.—A representation may be oral or written.

SEC. 2572.—A representation may be made at the same time with issuing the policy or before it.

SEC. 2573.—The language of a representation is to be interpreted by the same rules as the language of contracts in general.

SEC. 2574.—A representation as to the future is to be deemed a promise, unless it appears that it was merely a statement or belief or expectation.

SEC. 2575.—A representation can not be allowed to qualify an express provision in a contract of insurance; but it may qualify an implied warranty.

SEC. 2576.—A representation may be altered or withdrawn before the insurance is effected, but not afterwards.

SEC. 2577.—The completion of the contract of insurance is the time to which a representation must be presumed to refer.

[1] PATTERSON, E. W., "Essentials of Insurance Law," p. 238.

[2] In some states a defense of misrepresentation is only permitted when the loss arose from a cause as to which there was misrepresentation.

[3] In 1935 replaced by Secs. 350 to 360 of the Insurance Code.

SEC. 2578.—When a person insured has no personal knowledge of a fact, he may nevertheless repeat information which he has upon the subject, and which he believes to be true, with the explanation that he does so on the information of others, or he may submit the information, in its whole extent, to the insurer; and in neither case is he responsible for its truth, unless it proceeds from an agent of the insured, whose duty it is to give the intelligence.

SEC. 2579.—A representation is to be deemed false when the facts fail to correspond with its assertions or stipulations.

SEC. 2580.—If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time when the representation becomes false.

SEC. 2581.—The materiality of a representation is determined by the same rule as the materiality of a concealment.

The representation is the communication required to comply with the prohibition against concealment. Concealment is the passive, and misrepresentation the active form of the same thing.

A warranty is of the same nature as a representation though stronger. It is, of course, a much greater protection to the insurer against incomplete or misleading information. But the doctrine of warranty is a very harsh doctrine and, if strictly enforced, may work undue hardship on the insured. As the courts are reluctant to declare a forefeiture except as a penalty for patent bad faith, there is a tendency to be lenient in the construction of warranties but, if it is a clear case of warranty and not contrary to statute, the warranty will be enforced.[1]

Abuse of Warranties and Modern Legislation.—When the doctrine of warranties was first worked out, the practice of insuring was confined largely to merchants and shippers who, in many cases, were also underwriters and who, therefore, fully appreciated the force and significance of warranties. The development of fire insurance, covering private dwellings, and of personal insurance, life, accident, and health, however, brought in a new class of insured unfamiliar with the practice of insurance in general and with the legal theory of warranties. These

[1] Of course, if fraud can be proved, the insurer may repudiate the contract without relying on the doctrines just cited. It is exceedingly difficult to prove fraudulent intent, and these legal doctrines were developed to discourage fraud when the fact of fraud could not be proved.

insured often signed applications for insurance giving their best understanding of certain matters, and looked upon their statements as representations of no greater importance than would attach to them as such in ordinary commercial transactions. Sometimes the printed part of the blank made them warranties. Under stress of competition, it also was very often the custom for the agent of the company to fill out a schedule of warranties on a policy which provided that, by his acceptance of it, the insured warranted the truth of the statements in the schedule.

These practices tended to produce many unjust forfeitures, and these forfeitures, in turn, tended to a judicial softening of the old doctrine. In many states, legislation resulted providing, in regard to one or more kinds of insurance, that, in the absence of fraud, all statements should be deemed representations and not warranties.[1] This gives the insurer ample protection, since a misrepresentation of a material fact will make the contract voidable. Yet the unscrupulous carrier is prevented from taking technical advantage of the insured. Usually associated with such legislation, as an additional protection to the insured, is a requirement that a copy of the application or other document purporting to carry such warranties be furnished with the policy. This legislation does not apply to all branches of insurance, and in some, notably marine insurance, warranties are still used and enforced by the courts.

Term of Contract, Cancellation.—Risk, the basis of insurance, is not an evanescent instantaneous phenomenon but persists over a period of time, dependent upon the subject matter. Time, therefore, is an essential feature of all insurance contracts. All define in some way, usually by a specified date and hour, when the contract begins and for most kinds of insurance when it ends.[2] Sometimes, notably in life insurance, the contract is of indefinite duration but provides for periodic payment of premium as a condition of its continuance. Open contracts are common in

[1] So required *in re* life-insurance policies in New York. See also Statute *in re* Accident and Health Insurance Standard Policy Provisions found in the same (Insurance Law §107) and many other states.

[2] Some perpetual fire-insurance contracts are issued for which a single premium is payable in advance. Also some surety bonds run for an indefinite time without payment of additional premium.

marine insurance but provide for premium settlement at intervals. In most fields of insurance the great majority of contracts are for annual terms.

Even over so short a period as one year, interests in insured objects frequently change, and the insured no longer desire insurance. Usually insurance contracts are issued by agents who may accept risks which the carrier for which he is acting does not wish to carry. Conditions also may change, so that a risk, acceptable when the policy was issued, is no longer regarded as safe by the carrier. Insurance contracts, consequently, generally contain provisions for cancellation on equitable terms by either party on specified notice to the other party. Since the premium is usually payable in advance for the policy term, the insured is entitled to a refund of the premium he has paid for the insurance that he does not receive. On the general theory of the constancy of the risk during the term of the policy, the premium is regarded as earned pro rata over that term, and the "unearned" premium to be returned is the prorata part of the stated premium for the unexpired portion of the stated term. The cancellation provision usually specifies that on cancellation at the option of the insurer this shall be the return. The insurer, of course, is at some expense in issuing a policy and its cancellation involves, at least, additional clerical expense. Hence, it is thought that, if the insured cancels the contract, he should pay more for the shorter period for which he is insured than the prorata part of the premium for the full term. This is specified in the cancellation clause by providing that the refund shall be the excess of the premium paid over the customary short rate.[1] It should be noted that neither party is required to prove any misconduct of the other or take any other action or give any reason for so doing to entitle him to cancel. Cancellation is usually set up in the contract as a right for each party. In this respect it differs from most commercial contracts.

Although most insurance contracts contain a cancellation clause, there are certain types of contract where it would be improper. Thus, if a marine-insurance carrier had the right to cancel at its option a voyage policy on a cargo, it might do so

[1] The most common short-rate table for annual policies is shown in Appendix XII.

when the vessel was at sea and in grave danger because of stormy weather. The shipper would probably not be able to procure other insurance at the same rate and perhaps not at all. Such policies do not contain a cancellation clause. Life-insurance policies are issued at a level premium against an increasing risk and are not cancelable. The insured, under a life-insurance or other policy calling for payment of periodic premiums as a condition of its continuance, may terminate the contract on any premium-due date by failing to pay. If, as is usually the case, he has an equity in the policy, the manner of refunding it to him is provided by the policy terms.

Standard Forms and Provisions.—As the insurer is in the business of making contracts of insurance, while the insured enters into such contracts only occasionally and incidentally to other business or activity, the former is naturally the more expert in preparing the necessary documents and contracts. He is in a position to use his knowledge to his own advantage as against the insured. The record of insurance carriers for fair and honorable dealing is as good as that of the business community as a whole; but there have been carriers who have not had such high standards and, at different times, a majority of carriers in a particular field have taken advantage of their position, inserting unjust conditions in their contracts and using small type to prevent their discovery. The effective preventive of such practices is a statutory requirement of a standard form. Such standardization of forms is also highly advantageous where many carriers are involved in the same loss, as is often the case in fire insurance.

On the other hand, standardization prevents change and experiment—it is designed to prevent departure from what is prescribed. Change and experiment are the means of progress. Though standardization tends to check progress as to the items standardized, it may make for progress in other respects. If the liberalization of contracts has attained to a high degree, standardization is an advantage, but if there is yet room for extension, it will impede progress.

In fire insurance, standard forms have been required in most states for many years, the earliest having been adopted in Massachusetts in 1873, and in New York in 1886. In later

revisions there has been some liberalization, but until 1943 it has been mainly in minor points. Practice and legal construction have prevented hardship under the older forms.

Following an important investigation into life insurance by a committee of the New York Legislature, in 1906, standard forms were prescribed for life insurance, but, after two years, they were replaced by a statute requiring that certain provisions be contained in the policies and forbidding the use of others. Present-day life-insurance contracts are much more liberal than the forms originally prescribed by statute, so that the public has gained by the change. Standard-provision requirements are found in other lines of insurance; and in some, where neither forms nor provisions are prescribed, policy forms are subject to the approval of the state authorities.

Where the contract has been drawn by the carriers, the rule of construction of contracts is that doubts are to be resolved against the party who drew the contract. This has been true even when the carriers have drawn the contract in response to a mandate of law and when the contract so drawn has become the statutory standard.[1] There is doubt whether this will be the case where the contracts or standard provisions were drawn by state officials, and required by statute.

Special Clauses for Certain Types of Carriers.—In the case of certain types of mutual, reciprocal, and fraternal-order carriers,[2] the contract is required by law to contain specific provisions relating to (1) the policyholder's right to vote at an election of the company, (2) the policyholder's liability to assessment, if any, (3) the policyholder's right to participation in the earnings or surplus of the company, and the manner of its apportionment and distribution. These are necessary, as the policyholder, in taking his policy with such carriers, acquires rights and assumes duties in addition to those of the insured generally in relation to his insurer. Sometimes, also, there are special provisions in the charter of a corporation which have an important bearing on its

[1] For example, the New York Standard Fire Insurance Policy of 1886 was prepared by the New York Board of Fire Underwriters, to whom the law delegated the task.

[2] The characteristics of the different types of insurance carriers and the distinctions between them are discussed in Part III.

contracts. Clearly, they should come to the attention of the policyholder, and generally it is required that they be printed in the policy. In some cases, if these provisions restrict the benefits of a standard form, they are required to be made more conspicuous, either by the use of a particular size and style of type, or of red ink, or of both.

Modification of Basic Contract.—Although many of the terms of a contract are subject to standardization and embodiment in a printed form, the name of the insured and many other particulars identifying the parties and the risk have to be written in. Often, certain provisions that are generally desirable are not appropriate to a particular case, and further conditions are necessary to make the general policy fit the particular case. It is customary to add such clauses and modifications by endorsement, either written, stamped, or pasted on the policy. These have the same effect as though written in the policy, with the addition that, being subsequent in preparation to the basic contract, they are controlling in case of any doubt. The forms of few of these riders and clauses are prescribed by statute, and hence they are subject to the general rule of construction that doubts are to be resolved against the drawer.

Binders.—Not infrequently an agreement is reached that a policy is to be issued and will be accepted, but the insured desires evidence, before the policy can be issued, that the insurance has been effected. In such cases it is customary for the representative of the insurance carriers to issue a memorandum slip showing the risk to be covered, the date from which the policy is to be effective, the name of the insured, and the amount. The memorandum, really not a contract of insurance but an agreement to issue such a contract, is a "binder." Should loss occur before issuance and delivery of the policy, the insurance is recognized by the carrier as though the policy contracted for had been issued. Binders are not used in some lines of insurance, notably life insurance, where the acceptability of the risk must be passed on by the head office of the company. In life-insurance practice, when the applicant pays the first premium with his application, a binding receipt is given which puts the company on the risk from approval of the application, without waiting for the issue and delivery of the policy.

Another View of the Contract.—The major part of the obligation of the insured is carried out by the payment of the premium, while the obligation of the company is not ordinarily fulfilled until expiration of the policy, either by time limitation, or by payment of its face or maximum limit on the occurrence of a loss or losses. The contract is therefore sometimes said to be "executed" as to the insured and "executory" as to the insurer. Such contracts are referred to in law as unilateral. At first sight this seems untrue, since there are some contracts that are voided, or at least limited in their scope, by actions of the insured subsequent to their issuance, or even by his inaction, *e.g.*, failure to furnish proof of loss or to do other things required to be done at the time and after a loss has occurred. But only the insurer is legally bound to do anything. He must hold himself always in a position to carry out his bargain. It is his conditional and limited promise to pay—conditional upon the occurrence of the loss insured against and limited to the cash value of the loss, not exceeding the face of the policy. This point of view is of value when considering the financial condition of the insurance carrier, since such a promise is clearly a liability for the liquidation of which adequate provision must be made.

SUMMARY

1. The insurance contract in general is

   a. A contract for the purpose of transferring *financial* risk.
   b. A personal contract, even though in relation to property.
   c. A contract of indemnity.
   d. A contract of the highest good faith.
   e. Subject to the general rules of the law of contracts, and to judicial precedents and legislative enactments relating especially to insurance.

2. It follows from these characteristics that

   a. A valid contract may be based only on an insurable interest, such an interest as is endangered by the contemplated risk.
   b. The insurance carrier in settlement is entitled to subrogation of the insured's right to claim against those believed to be responsible for the loss.

c. Concealment or misrepresentation of material facts by the insured will vitiate the contract.
d. If the insured has warranted the truth of certain statements or the carrying out of certain promises, these warranties must be literally complied with.

3. Other characteristics:

a. The doctrine of warranties has been modified somewhat by judicial decision, and the use of warranties, by law.
b. In some lines of insurance, standard policies are prescribed by law; in others, standard provisions are required.
c. To fit the individual case, it is necessary to fill in blanks in standard forms and to modify them by riders and endorsements, which are controlling when in conflict with the basic form.
d. To meet the requirements of the peculiar character or the charter provisions of particular carriers, special clauses are required to set forth fully the rights and duties of the insured.

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CHAPTER VI

FIRE-INSURANCE CONTRACTS

Speaking before the Insurance Society of New York, David Rumsey, one of the country's leading insurance attorneys, said, "The fire-insurance policy is probably the most important contract in the world."[1] He did not elaborate his reasons for the statement, but the universality of the practice of insurance against fire supports it, whether from the point of view of the number of contracts issued or of the values covered by such contracts.

The ordinary fire-insurance contract insures against a single type of hazard, *viz.*, the financial loss due to damage or destruction of physical property by fire or lightning. It might seem that a single form could be drawn up, perhaps as simple as a promissory note, which would, in the light of precedent, express the contract to the clear understanding of all concerned. Such is not the case, however, because, although the hazard assumed might be of the same general nature in all cases, the differences in characteristics of the properties subject to the insurance, and of the interests in such properties to be insured, call for different provisions in the contract to meet the situation in each individual case. Nor can the form be as simple as might be assumed. The reasons for this will become apparent later in this chapter as the analysis of the contract proceeds. Despite these requirements, it is possible to use a basic general contract, attaching endorsements to meet the needs of individual cases. In this chapter will be discussed, first, the basic contract and, second, the endorsements in common use.

STANDARD FORMS

History of Standard Forms.—Owing to the heavy congestion of values in large buildings, accentuated by similar congestion in

[1] "The Fire Insurance Contract," p. 41.

surrounding buildings, and to the desire of insurers to spread their risks in such a way that excessive losses may not be encountered in single fires, it is frequently the case that several policies of different carriers are issued covering the same property.[1] In the event of loss, if the terms of the several policies are not identical, much confusion is likely to result; and, sometimes, the insured is not able to recover his full loss, though he might have done so had they all read alike. It is, therefore, desirable that policies covering the same risk be identical in their terms.

In the early history of fire insurance each company prepared its own forms, and much fine print was sometimes used, making restrictive clauses difficult to read. Sometimes the insured, sometimes another insurer, and sometimes even the shrewd company itself, was the victim of this practice. From time to time efforts were made to secure the adoption and use of standard forms. Earnest efforts along this line were made by the companies at the meetings of the National Board of Fire Underwriters in 1867 and in 1868,[2] but without success. In 1867, the Legislature of Connecticut adopted an act for uniform conditions, but the form was so unsatisfactory that it was repealed the next year.[3]

Massachusetts, which has set the example of reform in so many ways in regard to insurance, was the first state to pass a law providing for a standard policy. This was done in 1873,[4] and, with minor changes, this policy has continued in use until the present time. The policy was not liked by the carriers and not generally adopted by them for use elsewhere, though some states later required its use.

According to Elijah R. Kennedy, chairman of the committee which drew the first New York form,[5] sentiment for a standard form was crystallized in that state, when an attorney, who was also a state senator, nearly ruined his eyes and temper trying to decipher the fine-print clauses and secure a proper settlement

[1] Perhaps an even more important cause of writing several policies on a single risk is the desire of the owner to favor friends who are agents of different companies.

[2] BREARLEY, H. C., "Fifty Years of a Civilizing Force," p. 24.

[3] Chapter 121, Laws of 1867; Chaps. 4 and 7, Laws of 1868.

[4] Chapter 331, Laws of 1873.

[5] "The Fire Insurance Contract," pp. 20*ff*.

of the insurance on the building of the Buffalo Y.M.C.A. The reaction was not delayed by the fact that a fellow member of the Senate Insurance Committee had not long before been victimized through the fine-print provisions of one company's policy, though the other companies involved had made up that company's shortcoming. The result of an interesting lobbying and legislative battle was the passage of a law calling upon the New York Board of Fire Underwriters to prepare and file with the Secretary of State a standard policy and standard modifying endorsements. This was done, and the policy became effective in 1887. Many states adopted this form, and it was used by many companies in states not prescribing any standard form.

At the time of the San Francisco conflagration in 1906, no standard form was prescribed in California, and difficulties arose in the settlement of losses in that disaster. Certain companies flatly denied liability, because of special clauses in their policies relating to fires caused by earthquakes. A standard policy law was passed by the Legislature of 1907 but vetoed by the governor, who appointed a commission representing the various commercial interests of the state, including in the minority the insurance carriers, to draft a standard fire-insurance policy. The Insurance Commissioner was appointed chairman. The form recommended by this commission was adopted by the Legislature of 1909 and is still in use in California. It is a revision of the New York form of 1887 and has some unique provisions, theoretically permitting a very flexible contract, but the adverse publicity of red ink and large type required for the use of certain optional restrictive clauses has effectively prevented their general adoption by the carriers.

The example of the California form, which is considerably more liberal to the insured than the old New York form, led to a general agitation for revision of the old form and emphasized to the underwriters the desirability of a nationally uniform policy. As insurance had been held not to be commerce within the meaning of the interstate commerce clause of the Federal Constitution,[1] this could not be accomplished by federal legislation. In 1913, however, the Legislature of New York directed the

[1] *Paul v. Virginia,* 8 Wall. 168 (1868). Reversed in *United States v. South-Eastern Underwriters Association et al.,* 322 U.S. 533 (1944).

Superintendent of Insurance of that state to request the National Convention of Insurance Commissioners to undertake the preparation of a new standard fire-insurance policy. This request was complied with, and the committee reported finally in 1917. The policy so prepared was adopted in New York, effective Jan. 1, 1918, and was later adopted in several other states either officially or by the carriers. It was, however, not made uniformly effective in all states, and all the forms mentioned above were used in one or more states as late as 1943. From early in the 1930's there was agitation by many interests for revision and simplification of the policy and for greater uniformity. But many, particularly the carriers and their counsel, feared the confusion that a new form might cause while going through the process of court interpretation.

The National Association of Insurance Commissioners, in 1936, appointed a special committee to prepare a new form. After 3 years of work, a form was submitted and approved by the Association but failed of adoption in any state. Agitation continued, and a new form was adopted in New York, effective July 1, 1943. This form has since been adopted in 40 states, and in Alaska, the District of Columbia, and Hawaii, with little or no modification. It[1] will be discussed under the following heads:

1. General considerations.
2. The risk transferred.
3. Loss settlement procedure.
4. Miscellaneous provisions.

GENERAL CONSIDERATIONS

Basis of Issue.—No formal application and no formal representations are required to be attached to the policy. It has become the practice of owners of city property to permit freely the inspection of premises by the inspectors of the underwriters. Most cities also require filing of plans and specifications of proposed buildings before building permits are issued, and these are available to the underwriters. Insurance carriers have maps that show the location and types of construction of buildings in urban centers, and information given by these is generally more

[1] See Appendix I.

accurate than the owner would be able to give. With these available, the carriers feel able to issue policies without applications. The need of promptly covering property and the keen competition for business have long since caused this to become the general practice.

It is, however, the privilege of any company to insist upon a written application before it will issue a policy, or upon the attachment of certain warranties to the basic contract. In some parts of the country it is the practice to require a written application for insurance on farm buildings and other farm property, since the carriers have no adequate facilities for otherwise obtaining the necessary facts. This application is brought into the policy by the attachment of a warranty referring to it. When underwriting results have been unsatisfactory, there has been some suggestion that a more general use of applications would be desirable, but the practice has not yet been adopted, nor does it seem likely to be.

Parties to the Contract.—The name of the insurer appears at the head of the contract, and the subject of the first sentence is "this company," implying, of course, the one whose name appears at the head. The company is bound by the signatures (usually a facsimile reproduction) of its president and secretary to the attestation clause on the first page and requires countersignature by its authorized agent at the place where the contract is issued. The name of the insured is to be written in as the object of the verb "does insure" near the head of the contract and should be followed by a statement of the nature of his interest, since the insuring clause limits the amount recoverable to the cash value of "the interest of the insured." The insurance also covers his legal representatives. Thus the policy covers an heir or executor under a will or a receiver in case of bankruptcy.

It is hardly possible under this language to mistake who is the insured under the contract, provided his interest is real and is clearly stated. In other words, the policy is an "interest" policy. It covers the insured while he has the interest named. It should be noted also that it is important that all parties having an interest in the property be specifically named in filling out the policy. It is imperative if they are to have any benefit from the insurance.

Consideration—Premium.—As consideration are named the stipulations and the *premium*, which is usually in one sum covering the entire period of the policy.

In the case of insurance on the contents of mercantile and manufacturing premises, where the stock fluctuates in quantity and value, such a contract makes it necessary for the insured to carry continuously an amount of insurance equal to the maximum value of his stock and pay premiums for more insurance than he needs at other times, or to take less and run the chance of a loss exceeding the insurance, or continuously to watch his stock and his insurance and add or cancel insurance (at the higher short rates) to keep it in step with his stock. These alternatives entail either excessive expense, risk, or labor, or all of them. Hence under stress of competition *reporting forms* have been developed in recent years.

These forms,[1] to be attached to the policy, provide for a provisional amount of insurance, or a stated percentage of the total concurrent insurance, with maximum limits set for property in each location and contain an Adjustment of Premium Clause of which the following is a specimen:

Adjustment of Premium Clause. The premium named in this policy is provisional only, and in no case shall be less than $100.00. The actual premium consideration for the liability assumed hereunder shall be arrived at by the following method: The insured hereby agrees to report to this Company not later than .... days after the first day of each month following the date of inception of this policy, the exact location of any property covered hereunder, the total value of such property in each location and any other insurance in force at any of such locations on the last day of the preceding month. At the expiration of this policy and after deducting specific insurance, if any, at each location, an average of the total remaining values reported at each location (but not in excess of the limits of liability herein established) shall be made, and if the premium on such average values at the rate applying at each location, exceeds the provisional premium, the insured shall pay to the insurer an additional premium for such excess; and if such premium is less than the provisional premium, the insurer shall refund to the insured any excess paid hereunder; provided, however, this Company shall in any event retain not less than $100.00. If this policy is written for a term of more than one year, an adjustment of both the premium earned

[1] See p. 83.

and the amount of deposit premium shall be made annually as herein provided.

RISK TRANSFERRED

Description of Risk Assumed.—The description of the risk assumed by the company must include a description of the property and of the loss in respect to it for which the company will be liable. The precise description of the individual property covered by the policy must be given by endorsement in the place provided on the third page of the policy for that purpose. In other respects, the basic risk is described on the face of the policy.

The insurance afforded is "*against all direct loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy, except as herein-after provided,*[1] occurring within certain time limits set in the policy. This language is not so broad as it appears on first reading. The coverage is limited in three ways on the face of the policy and by certain clauses in the stipulations on the second page. The amount recoverable for loss or damage is limited to

1. The extent of the actual cash value of the interest of the insured at the time of the loss.
2. The cost of repair or replacement within a reasonable time with material of like kind and quality.
3. The amount of the policy named on its face.
4. That portion of the loss which the face of the policy bears to the total insurance covering the same property.

The cash value of the insured's interest is presumed to be ascertained with proper deduction for depreciation, though it is not so stated in this form as it was in earlier forms, and is stated to be without compensation for loss resulting from interruption of business or manufacture. In determining replacement cost, only cost of restoration to the condition at the inception of the fire may be considered, even though it may not be permissible in law to restore to that condition.

The reasonableness of the four basic limitations is apparent. A brief consideration of the further restrictions just mentioned will also demonstrate their reasonableness. Though the insured may not be able with his insurance money to replace his property

[1] As is noted later in this chapter the insurance may cover perils other than those of fire or lightning.

in as good condition as before the fire (he will have to replace new for old, and the old was still amply serviceable for him) yet, if depreciation were not deducted, a temptation would be placed before the insured to rid himself of his depreciation by "selling the old stuff to the insurance company" through a fire for enough to replace it with new. This would be bad not alone for the company but in the long run for all, for through higher premiums all would "pay the freight" on the evil practice. The same reasoning applies to the limitation to cost of replacement, without regard to higher required standard of construction, because otherwise a convenient fire would allow an out-of-date building to be brought up to date at the expense of the company.

It is not often that a building can be restored after a serious fire to usable condition except by the use of new material. The insurance payment based on cash value less depreciation will rarely, if ever, cover the cost of such restoration. This may leave the insured, desiring to restore his building and resume business in the old location, in an embarrassing position if his free resources are limited. Hence there has arisen a demand for insurance on a replacement-new basis. This demand can be met if the moral hazard can be controlled. It is believed that the moral hazard is practically eliminated if the insured is required to restore forthwith and his payment from his insurer is limited to the actual cost of restoration. Such insurance is now offered by an endorsement on the policy providing for payment on this basis. When the insurance is so written, it is on a 100-per-cent coinsurance basis[1] relative to the cost of construction of a new building at the time of the loss. This is a recent development and is not yet (October, 1945) generally available.

Of course, fire intentionally set by the insured is not covered by the policy, but fire tends to obliterate the evidence of its cause, and the person expecting to profit by it usually thinks he can conceal his crime.

The policy does not of itself limit the kind of fire, loss from which will be covered, but by common law two kinds of fire are distinguishable: friendly and hostile. Fire in its proper place is highly useful and is known as a "friendly" fire. Fire not so confined is dangerous and destructive and is known as a "hostile"

[1] See pp. 90–95.

fire. The contract is held to cover only loss or damage by a hostile fire. Hence, destruction of jewelry or other valuables, accidentally falling into the fire in the stove or on the hearth, is not covered by the policy. If the fire rolls out of the grate across the hearth and onto the rug in front, its character is changed into that of hostile fire, and the loss is covered.

Mere heat is not fire, and damage due to scorching of paint by an overheated stove is not damage by fire within the meaning of the policy. There has been no fire except within the stove, and that is a friendly fire. If a pan of grease on the stove takes fire and, without igniting anything else, creates such a thick greasy smoke as to ruin paint that must be repaired, the resulting loss and damage are caused by a hostile fire and are covered by the policy.

The policy provides on its face that it is subject to the stipulations and conditions therein stated, including those on the following pages and such other provisions, stipulations, and agreements as may be added, as provided in the policy. Several of these conditions aid in the description of the risk (1) by specifying certain property as uninsured and (2) by specifying certain perils as not covered. Each of these falls into two classes, one of which may not be covered under the policy, while the other may be covered by proper endorsement.

Fraud, Misrepresentation, Etc.—Fraud, of course, will vitiate any contract, and it has already been noted that the insurance contract is one of the utmost good faith. But to make assurance doubly sure and amply warn any who may come to have any interest in the contract, it is specifically provided that the entire contract shall be void, " . . . if, whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein." It is also made void by fraud or false swearing by the insured, whether before or after a loss. The propriety of such a provision is so self-evident that the only further comment apparently called for is that it should be remembered that a principal is responsible for his agent when acting within the limits of his agency. The prospective insured, securing his policy through a broker,[1] should

[1] See Chap. XIX for discussion of brokers and their functions.

see that the broker is fully advised of all conditions affecting the risk and is a man whose integrity can be relied upon. The same precaution should be observed in employing a public adjuster, or any other agent, to represent the insured in settlement of losses.

Uninsurable and Excepted Property.—Where the property covered is described by endorsement, it would appear that specification of certain property as not coverable, or as not covered, was unnecessary. This would be true if all endorsements were inventories of specific items covered. In order effectively to meet the needs of business, however, description must be in general terms. Hence, unless there are exclusions elsewhere, the general terms might be held to include risks that the underwriters were unwilling to assume.

An examination of the list of uninsurable property in lines 8 and 9 will disclose that it is either of value to the owner alone and often replaceable at a nominal cost only, *e.g.*, accounts, deeds, evidence of debt;[1] or a circulating medium, *e.g.*, money or currency, which is easily removable, easily disposed of, and difficult to identify. Covering of such property is an invitation to fraud.

The property that may be covered by specific endorsement, though not included in general descriptive terms, again falls into two classes. It is either of such high intrinsic value that the insurer properly imposes special terms for its coverage, or else of such uncertain value that he insists on knowing what is covered and in what amount.

Perils Not Covered.—Although it is proper for a property owner to insure against loss or damage due to public disorder, it is not ordinarily contemplated as a fire hazard. As fire is often an accompaniment of such disorder, fires so arising are properly excluded from the coverage of the contract. A time of fire is always a time of confusion, and conditions are favorable for the operation of thieves. Insurance against theft is proper, but again it is proper to exclude losses due to theft from the coverage of a fire policy. The third exclusion in this group is of a different character.

[1] If not replaceable at nominal cost, measure of damage after fire might be the debt itself, or value of property represented by unrecorded deed destroyed by fire. There are many reasons why the companies are unwilling to assume this risk.

This company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly . . . by neglect of the insured to use all reasonable means to save and preserve the property at and after a fire or when the property is endangered by fire in neighboring premises.

The propriety of such exclusion and its conformity to public interest are so obvious as to render discussion unnecessary.

Losses caused by order of civil authority, if not due to fault of the owner, may generally be recovered by suitable action at law against such authority. Such losses will generally be in destruction of a public menace, when the property has changed from a community asset to a liability. There is, however, an occasional exception to this condition. In a general conflagration, sometimes the only way to check the spread of the flames and save the remainder of the community is to raze, by dynamite or other explosive, buildings in the path of the flames. The policy disclaims liability for loss

. . . by order of any civil authority, except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided such fire did not originate from any of the perils herein excluded.

As to this group of limitations, there is no provision for coverage by endorsement.

Perils Not Covered in Basic Form, but Coverable at the Option of the Parties by Agreement.[1]—There are certain conditions likely to be present, temporarily or permanently, which materially increase the hazard of a particular risk. Some, if not most, of these the insurer, for a proper additional premium or for no addition, may be willing to accept, but he is clearly entitled to know that he is taking over such a risk. The condition may not be present or even contemplated when the policy is issued, but may arise during the life of the policy. This is provided for by, in effect, suspending the policy during the continuance of the conditions unless the insurer specifically assumes the risk.

Other Insurance.—In the earlier policies the insurer was not liable if there was other insurance without the company's consent. In some cases the existence of an excessive amount of

[1] New York Standard Form Fire Policy, lines 28 to 37. See Appendix I.

insurance increases the moral hazard. Hence the provision against other insurance without consent. In most cases the added form gave the required consent. This policy approaches the problem of overinsurance in the opposite way. Consent to other insurance is not universally required. The company, however, is specifically authorized to prohibit other insurance or to limit its amount by endorsement attached to the policy.

Chattel Mortgage.—The existence of a chattel mortgage was once thought to create an increased hazard in connection with property mortgaged and, prior to the adoption of the California standard form, the existence of such a mortgage, unless disclosed to the company and sanctioned by suitable endorsement, invalidated the entire policy. In a policy designed to cover a variety of conditions, this was felt to be too harsh in application though sound in principle. Hence it was modified in the drafting of that form, and the modification there initiated was continued in the 1918 New York form, so that the presence of the mortgage merely operated to release the insurer of liability in respect to the property subject to the mortgage. The provision has been eliminated from the present policy. This is only one of many liberalizing changes.

Other Perils or Subjects.—Companies writing fire insurance are often, in fact usually, permitted by their charters to write other lines of insurance. The contents of buildings are exposed to hazards other than fire damage. Sometimes the buildings themselves are also so exposed. As the public has become more risk-conscious, insurance aganist these other hazards has been sought. The need of keeping track of many policies is annoying and sometimes, through oversight, necessary insurance has been allowed to lapse. There has been demand for an "all-risk" policy on buildings and their contents similar to the marine policy on goods in transit.[1] The laws of most states do not yet permit this, but the clause permitting other than fire risks to be included in the fire policy, first appearing in the present New York policy,[2] is a first step in that direction.

Prorata Liability.—Under the theory of indemnity, the insured should not receive more by way of insurance than he has

[1] See Chap. VII.

[2] Lines 38–41.

actually lost. Very often the property of an individual requiring insurance protection fluctuates quite widely. His needs could be covered only if his policy were to expand and contract in amount of coverage as his stock of goods expands and contracts. This may be most inconvenient to both parties to the contract, and both may be better served by the use of several contracts. Also, as has been already noted, in order to avoid overloading one carrier and yet give the owner of a large building full coverage, the use of several carriers is very often desirable. However, in order that one policy may not take the entire strain, and a second be merely a cover for the value in excess of the first, a clause such as the one headed Prorata Liability in the standard form is needed:

This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property, whether collectible or not.

It may at first seem a hardship that the insured, having sufficient valid insurance in solvent insurers, should not be fully reimbursed because some of the other carriers were unable to meet their responsibility. Were this clause not present, so long as a property owner protected himself in strong companies up to the limit beyond which losses seldom run, he would be reasonably sure of indemnity for most of his probable losses, and he might then add insurance at cut rates in less reliable companies. Only in the case of a large loss, and then only partly, would he feel any penalty for bad judgment in such an action. The encouragement of poor business judgment, and the cultivating of the irresponsible at the expense of the responsible, would in the end be bad for all concerned.

Term of the Policy.—The *time limitation* of the risk transferred is expressed on the face of the policy both by specifying its length and its beginning and ending. The beginning and ending dates are to be inserted, and following them are the words "at noon, Standard Time, at the location of the property involved." It should be noted that the hour is set according to standard time.

PROCEDURE IN EVENT OF LOSS

Since the essence of the transfer of the risk is the insurer's promise to pay the loss, it is important that the contract trans-

ferring the risk should make clear just what shall be the procedure for collection under the policy. The insurer is clearly entitled to all information necessary to ascertain the fact of the loss and its true amount, and to determine his liability under the contract. Although the procedure called for by the various standard forms is essentially the same, in the California form it is worked out in a precision of detail, with time limits at each step and a clear specification of whose duty it is to make the next move that has apparently seemed too cumbersome to the drafters of the form under discussion. The essential duties imposed on the insured in settlement of losses are (1) to give immediate written notice of any loss, (2) to protect the property from further damage, (3) to separate the damaged from the undamaged property, (4) to make and furnish the company with an inventory of the damaged and undamaged goods, and (5) to submit a formal proof of loss. The contract contains a rather precise statement of what must be furnished in the proof of loss. There is nothing in these requirements that should embarrass an honest man accustomed to businesslike procedure, though the claimant seeking to defraud would probably find them not a little annoying. The formal proof of loss must be submitted within 60 days of the occurrence of the fire, unless the insurer extends the time. Fulfillment of this requirement is a condition precedent to collection of the loss.

Appraisal.—It is a time-honored practice, when two parties cannot agree, to call in one or more to settle the dispute. In the fire-insurance contract this practice is brought into play, where it is impossible to agree on the amount of loss or damage, by providing that either party may demand an appraisal by two appraisers, one appointed by the company and the other by the insured, who are required to agree on an umpire and then to appraise the value of the property involved and the loss. The award of any two is binding.

Appraisal is an expensive process and is to be avoided where it reasonably can be. Though each of the appraisers is appointed by his own side, the proceeding is in no sense intended as an arbitration, but as an independent and expert evaluation of the loss.

Company's Options.—The company has the option, on giving suitable notice (there is some difference in the time requirements

of the different forms), of taking any or all of the damaged personal property at the agreed or appraised value. And this is often done when the company can recondition and sell it to advantage. The reciprocal right of abandonment is not, however, given the assured. To do so would probably be socially detrimental, for it would often tend to assist a dishonest claimant in securing a net gain from the fire. The company on similar terms may repair, replace, or rebuild the property with other of like kind and quality. But this right is seldom exercised since it would almost of necessity involve the giving of new for old.

Time for Payment.—The company is allowed 60 days after the final settlement of the loss to make payment. In times of financial stringency this may be availed of, but most losses are paid within this limit.

Subrogation.—As was noted in Chap. V, the company is subrogated to the extent of its payment to rights of recovery against any party claimed to be responsible for causing the loss.

Suits.—The policy contains a short statute of limitations which differs in different forms from 12 months (in the 1943 form) to 18 months after the fire. The difficulty of properly defending such a suit unless begun within a reasonably short time is the justification for this clause.

MISCELLANEOUS PROVISIONS

Added Provisions—Waiver Provisions.—Under these two headings the policy provides for the modification of its terms by addition of clauses defining the risk, and otherwise modifying the contract in ways not inconsistent with its fundamental terms. It also attempts to prohibit waiver of any of its terms, except those which the policy indicates may be waived, and to prescribe that such waivers as are permitted must be in writing added to the contract. It further attempts to make sure that the company's action in ascertaining the extent of loss and examining the case shall not be held a waiver of any of its rights. Some of the earlier forms tried to carry these attempts further by specifying that no one should be deemed the agent of the company, unless duly authorized in writing.

Although the company is entitled to all reasonable protection,

it appears that these provisions are, in most jurisdictions, futile, because they run afoul of general legal principles and, if rigidly construed, would work grave injustice to the insuring public. For example, if a company intentionally or through negligence allowed it to be generally understood in a community that a given person was its agent, and especially if it profited by that understanding, it would be a grave injustice to refuse to recognize that agency in connection with a particular contract. It is a general legal principle that an agent has such powers as, with the active or passive consent of his principal, the public is led to believe he has, and there appear to be no reasons why the rule should not apply in the insurance business. As it is not the general policy of insurance companies to advertise limitations on the powers of local agents issuing policies, they are usually held to have general powers to bind their companies.

This latter attitude is of particular importance, because of the further general principle that, with the consent of both parties, even written contracts may be modified by oral agreements. If the agent, representing his company, orally waives any of the requirements of its contract, the company is held to be bound by his action. The prohibition against this being done, except in a prescribed manner, is one of the terms that may be waived and, with this waived orally, the way is open to other oral waivers.

The situation is further complicated by the general principle that, if one party to a contract, either by words, or acts, or neglect to act, leads the others reasonably to conclude that he has waived certain provisions of the contract, it will be held he has done so, and he will be estopped from later claiming the benefit of the provision. This is known in law as "estoppel."

Although the necessity of doing business through agents of various kinds, coupled with the legal theories of waiver and estoppel, at times places the insurance carriers in the position of being forced to carry a different risk than was contemplated under the contract, the courts generally endeavor to deal fairly with all concerned and to protect their reasonable interests. It will not do, therefore, for an insured to neglect the use of reasonable care in the protection of his own interests, relying upon these legal doctrines to save him from the consequences. He should read his contract carefully and see to it that agreement with the

agent modifying its set terms is endorsed upon it in writing as provided in the contract.

Cancellation.—The company reserves the right of cancellation of the contract on 5 days' written notice, which must be accompanied by a tender of, or specify, its readiness to pay the prorata portion of the premium for the unexpired period on demand. The insured may cancel at any time, but is charged at a higher rate, legally and commonly known as "short rates" for the time covered, because of the extra expense involved. A table for short-rate cancellation is recognized by the courts and used by all fire carriers.

Mortgage Interests.—A very large number of fire-insurance policies are made payable to mortgagees as additional security for their loans. Holders of mortgages have generally been able to get very favorable terms for such insurance. The covering of such interests is usually by endorsements, and the terms of the coverage are usually set forth quite fully in the endorsement for which there is usually no additional charge. The standard contract contains certain provision in contemplation of mortgagee endorsements. Cancellation as to such interests is on 10 days' notice, instead of 5.[1] If the insured fails to prove the loss, the mortgagee must do so within 60 days of notice of the failure, and he is subject to the other provisions regarding settlement of loss. If the company claims that it is not liable to the insured but pays the mortgagee, it is subrogated to the extent of the payment to the mortgagee's rights. It also has the option of paying the entire mortgage debt and requiring an assignment of it.

ENDORSEMENTS—FORMS AND CLAUSES

It is beyond the scope of this book to attempt an exhaustive discussion of the form of all the various *endorsements*, or *riders*,[2] used to modify the standard contracts. They fall into two classes: *forms* and *clauses*. Some of the earlier standard-policy laws limited the use of endorsements to those set up in the law. Some of the later statutes have provided in substance that clauses may be added such as those

[1] Only 5 days' notice under the California standard form. This is the only provision as to mortgagee interests in that form.

[2] The terms "endorsement" and "rider" are used interchangeably.

1. Covering property and risks not otherwise covered.
2. Assuming greater liability than is otherwise imposed on the insurer.
3. Granting insured permits and privileges not otherwise provided.
4. Waiving provisions for avoiding the policy or suspending the insurance.
5. Waiving requirements imposed on the insured after loss.

Clauses are also permitted defining the rights and duties of mortgagees and, with specification in some states of size of type to assure adequate notice to the insured, imposing duties on the insured, and limiting the liability of the insurer. The latest standard form contains the provision in this respect under the *added clauses* provision, which reads as follows:

> The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other agreement not inconsistent with the provisions of this policy, may be provided for by agreement in writing added hereto. . . .

Even though endorsements are not standardized by law, the importance to the carriers of uniformity in coverage of risks, where several carriers are involved, is such that they are often standardized by the carriers through associations covering particular territories. It will be well to examine some typical endorsements in common use in order to understand their import and purpose. This should aid in understanding similar endorsements which are not discussed.

Description.—The description of the risk is written upon a *form* which is pasted on the policy in the blank space provided for it. The form usually carries, in addition to the description, such permissive and restrictive clauses as are appropriate to the risk to be covered. A typical form, and one necessarily found on a large number of policies, is the Dwelling and Contents Form.[1] This form shows the location of the property, and there appear several items with a space for entry of amounts covered on each and a printed general description of the class of property included. There are also blanks for the insertion of written description of other classes of property covered by the

[1] See Appendix II for copy as prepared by the Eastern Underwriters Association and recommended to the rating organizations in the New England and Middle Atlantic States. Forms used in other parts of the country are substantially similar.

policy. All blanks may not be filled. The insurance covers only the property opposite whose description an amount appears.

It will be noted that the form permits, for an additional premium set up therein under the term "extended coverage," the inclusion of insurance against certain risks other than that of loss by fire.[1] It sets forth the conditions and limitations of such insurance. It also provides for the inclusion of *rental-value insurance*[2] in the same policy.

The restriction relative to item 2 that losses on this item "shall be adjusted with and payable to the Insured specifically named" should be noted. Although the insured is permitted to include under this item the property of other members of his family permanently living with him, the company would be put to much trouble and uncertainty if it were necessary to adjust losses on this property with and pay them to the individual owners. It might also face conflicting claims of its named insured and the others. This requirement, therefore, protects the interests both of the company and of the named insured who presumably pays the premiums. Such restriction is not placed on the other items. The property covered by them may be subject to a mortgage, and it may be both appropriate and desirable to provide for payment to a mortgagee or other person. The provision for such payment to others may be added to the policy by further endorsement.

The policy, by its terms, covers losses occurring within its term up to the limit set by its face amount. If payment is made for a partial loss, the policy thereafter covers only for the excess of the face amount over the payment. If the insured desires the full original amount to cover, he must purchase additional insurance equal in amount to what he has been paid. If the amount is small, this is something of a nuisance to him and the company. The form provides for automatic reinstatement without additional premium on payment of any loss not exceeding $250. Certain restrictions in the basic form are set aside wholly or conditionally, *e.g.*, permission is granted for the premises to be unoccupied without limit of time but only if the

[1] The authorization for covering such risks in the basic policy has already been noted. See p. 77.

[2] See discussion of rental-value insurance on pp. 98–99.

property is under the protection of an organized fire department. Since the form is drawn for possible use in territory where the 1943 policy has not yet superseded an earlier form, there are permits included that are not necessary under the 1943 form.

Another type of descriptive form is the *special-hazard* form.[1] This form is similar to the former in providing for the insuring for specified amounts of several types of property but, instead of using the general inclusive language in the dwelling-house form, an effort is made to break up the coverage into detailed parts. In order to prevent misunderstanding of general terms and yet avoid repetition of qualifying language, brief terms are used in the face of the form and are more fully defined on the back. The permits that are granted with these are peculiarly appropriate to the type of risk covered. Attention is specially called to the *Railroad Subrogation Waiver*, and to the restrictions on the kind of release that may be granted the railroad by the insured, without invalidating the policy, as an indication of the need of meeting peculiar conditions. The insured is permitted to grant release *before a loss* only, and when required to do so "as a condition of obtaining side tracks or other accommodations." The rate on such risks may be higher to compensate for the value to the insurer of the subrogation rights so waived.

This form does not recite the specific amount in which each named item is covered but is so worded that the policy covers that proportion of the amount entered for each item, which the face of the policy bears to the total of the amounts entered for the several items. This is known as a "schedule form," and is used for risks that are of such large value that several policies will be required to give full coverage. Such a method is used to assure that all policies on the risk cover in exactly the same way. Where there are several policies, confusion arises in apportioning losses among the several carriers, unless all policies read exactly alike. When clauses attached to the policies do not read alike, that is, when they are *nonconcurrent*, it is sometimes impossible for the insured to receive the benefit of all the insurance for which he has paid. So important is the need of con-

[1] In fire-insurance circles the term "special hazard" is used to designate a manufacturing risk of a hazardous type. See sample forms in Appendix III.

currence in the forms, that many companies print on the filing back of the standard-policy form, a warning substantially as follows: "It is important that the written portions of all policies covering the same property read exactly alike. If they do not they should be made uniform at once." This is a required part of the 1943 policy.

Endorsements Covering Property Not Otherwise Covered.—Any exempted property which it is desired to bring under a policy should be covered by a specification in the form. For example, if it were desired to insure highly prized manuscripts excluded by line 10 of the standard form, it might be done by using the blank lines on the covering form.

Endorsement Covering Hazards Not Otherwise Covered.—The policy may be extended to cover loss or damage for which the company is not liable under the terms of the standard policy. This is done by the addition of clauses or permits. Sometimes these are embodied in the form, *e.g.*, the Extended Coverage Provisions of the Dwelling and Contents Form. Another example of such provision is the following found in many forms prepared by the New York Fire Insurance Rating Organization:

> Permission is hereby given to make alterations, additions or repairs and this policy (so far as it applies on building) shall also cover in accordance with the conditions of this policy all materials and supplies therefor, therein, or adjacent, and such alterations or additions, and (so far as it applies on contents) shall extend to cover in such additions

Sometimes such permits or extensions of coverage are separately attached because the need of them is found in the individual risk but not in the general class. An example of this case is that of a building in course of construction. The following clause may be attached to the policy:

> The building described hereunder being in process of erection, permission is granted to install all fittings and fixtures pertaining to the service thereof, and to set up and test machinery to be used therein, and to complete and/or occupy and/or operate same; and this policy shall also cover materials to be used in the construction of said building, while contained therein, and/or on the premises and streets immediately adjacent thereto.[1]

[1] A form widely used on the Pacific coast.

Sometimes a permit or extension is for a limited time and at an extra premium as, for example, when permission is granted to carry on for a limited time a hazardous process like the operation of a motion-picture machine or for vacancy or unoccupancy beyond the 60-day limit of the policy.[1] Sometimes the company may be willing to extend the coverage if certain conditions are met and the permit may carry a warranty with it as in the following case:

In consideration of \$........ additional premium and the compliance by the insured with the following warranties, permission is hereby given to use in the building described in the .... item of this policy a .... gasoline engine, manufactured by .... at ...., for a period of .... from .... to ...., at noon, and during such period to keep in the building or within five feet of same for use not to exceed ten gallons of gasoline, unless otherwise allowed under specific permit, the same to be kept in an air-tight, closed metallic can free from leak.

The permission hereby granted is operative only when not in violation of any law, statute, or municipal restriction.

Warranties: That no reservoir shall be filled or can or package containing gasoline, naphtha, benzine or any of the light products of petroleum be opened, or the fluid handled, while any fire, blaze or artificial light (except approved incandescent electric light) is burning in the room or any room adjoining with open communication.[2]

The 1943 policy does not, like its predecessors, specifically prohibit some of these conditions, but it is suspended "while the hazard is increased by any means within the control or knowledge of the insured."[3] The question whether there is such an increase is a question of fact, not of policy interpretation. In a trial in court of a disputed claim this question would be left for determination by the jury. With these permits in the attached form or endorsement, so much of the increase of hazard as they cover does not suspend the insurance.

Changing the Insured Interest.—The policy as printed by the companies carries a blank form for assignment of the interest of the insured under the policy, and for the necessary consent of the company to the assignment.

[1] See Appendix IV.

[2] A New York form.

[3] Lines 31 and 32.

Adding an Interest.—The most common type of endorsement used to add an interest to the policy is the *mortgagee clause.*[1] This clause creates a new contract, supplementary to the first or basic contract.

The mortgagee does not have control of the property securing his loan and is not in position to prevent the insured from invalidating the policy by violating one or more of its provisions. If the interest of the mortgagee is to be properly protected, the policy should not only be payable to him but be kept in force insofar as it covers him, even though it is void as to the insured owner. This is provided for in the mortgagee clause. In return, the mortgagee agrees to pay the premium if the mortgagor or owner does not, to notify the company and pay the additional premium required if an increase in hazard comes to his knowledge, and to assign by subrogation to the company a claim for the amount of loss paid to him if the company claims that it is not liable to the owner.

The mortgagee is able to get such favorable terms because generally mortgagees and others who control credit can impose upon borrowers whatever requirements they deem necessary for their protection, and competition for the business they control forces the companies to make such concession. The companies are willing to grant them because, if not liable to the insured, they may on paying the mortgagee be subrogated to his claim against the insured.

Endorsements Defining the Application of the Insurance to Particular Items.—Sometimes the insured wishes a policy to

[1] See Appendix V. A "mortgagee clause with full contribution" is in some jurisdictions used alternatively or in place of the New York clause. It is similar to the New York standard clause but carries the additional provision, "In case of any other insurance upon the within described property, this company shall not be liable under this policy for a greater proportion of any loss or damage sustained than the sum hereby insured bears to the whole amount of insurance on said property, issued to or held by any party or parties having an insurable interest therein, whether as owner, mortgagee or otherwise." There is grave question whether this does not conflict with the provision that the insurance "shall not be invalidated by any act or neglect of the mortgagor or owner." The owner might procure additional insurance without the consent of the mortgagee and without the attachment of a mortgagee clause. The mortgagee will do well to refuse to accept such a clause.

float over and cover several parts of his enterprise or plant as, for example, in insuring the stock of a manufacturer which may be stored in varying quantities in different buildings of his plant. The quantities in each building will be constantly changing, and it would be impossible to specify a fixed amount in each building. He may take a policy to cover the stock in all the buildings. But it would be unfair to the company to do this without limitation. For, if there were, say, four buildings, and the stock fairly equally distributed, the insured might carry insurance equal to about 30 per cent of the value, and fully cover the stock in any one building. The company would then be covering four risks for the price of one, since it would be called upon to pay for whichever building burned. To prevent this, a clause is attached,[1] which provides that the coverage on stock in each building is at all times that proportion of the face of the policy which the value of the property in that building bears to the value of all property insured by the policy. This is fair to both parties. Similar clauses are used to meet other situations where special definition of the coverage is required.

Clauses Limiting the Company's Liability.—There are special warranty clauses, and other clauses limiting the liability of the company,[2] an explanation of which would unduly lengthen discussion if they were considered extensively. But there are two of these clauses which are of such importance and are so often misunderstood that special consideration should be given them.

Three-fourths-value Clause.[3]—In country districts, and elsewhere beyond the range of organized fire departments, if a fire starts and obtains any considerable headway, the entire premises are usually destroyed. Only the owner and his friends and neighbors can do anything to check it or save anything. If the owner has insurance equal to the value of the property, there may be no incentive for him to use great effort to minimize the loss. It is desirable in such cases, and in cities where frequent losses of large amount indicates inefficiency in the fire department and indifference of the citizens, to furnish an incentive to the

[1] See Appendix VI.

[2] See examples in Appendices VII to IX.

[3] See Appendix X.

insured to prevent loss by not insuring to full value, thus leaving him a chance of loss if he does not prevent it. Country properties are usually inaccessible, and it is difficult for the companies to inspect and be sure that the amount of insurance does not equal or exceed the value of the property. The *three-fourths-value* clause is used for this. It provides that the insured will not receive payment for loss in excess of 75 per cent of the value of his property, even though he succeeds in securing contracts for more. A more drastic restriction sometimes is imposed by using a *three-fourths-loss* clause which provides that the company will pay not more than its prorata share of three-fourths of any loss.

Coinsurance Clause.—The conditions described above are reversed in the case of property under protection of the organized fire departments of large cities. Except in the case of general conflagration, a total loss is almost never experienced. Sometimes the loss is confined to a single room, a closet, a basement, or a few shingles on the roof. In other cases more substantial damage is done. The first table on page 91, taken from the report of a committee of the New York Legislature, shows the distribution of an average 100 losses as found in one investigation of a substantial sample assuming $100 value in each case.[1]

Under such circumstances the rate charged per $100 of insurance should vary with the ratio of the amount of insurance to the value of the property. For example, assuming that 10,000 buildings of equal value are insured, that one fire occurs per 100 houses, and that the extent of the damage is as defined by the first table, the committee found the scale of rates shown in the second.

But with the privilege granted the insured to cancel any policy at will, there is no way for the insurer to know that, if he charges a rate corresponding to the amount of insurance carried when his policy is issued, this amount will be continuously carried, unless he attaches some clause that penalizes the insured if he does not carry that amount of insurance. Since the insurance carrier is only a redistributor of the losses incurred among its policyholders, the insurer (company) owes it to its policyholders who carry insurance to nearly full value to see

[1] *Report of the Joint Committee of the Senate and Assembly of the State of New York*, Feb. 1, 1911, p. 83.

On the average, out of every 100 fires:

82 that do a damage of less than $10 on the average $2, making altogether a loss of	$164
6 that do a damage of less than $20 and more than $10 on the average $14, making altogether a loss of	84
3 that do a damage of less than $30 and more than $20 on the average $25, making altogether a loss of	75
2 that do a damage of less than $40 and more than $30 on the average $35, making altogether a loss of	70
1 that does a damage of less than $50 and more than $40 on the average $45, making altogether a loss of	45
1 that does a damage of less than $60 and more than $50 on the average $55, making altogether a loss of	55
1 that does a damage of less than $70 and more than $60 on the average $65, making altogether a loss of	65
1 that does a damage of less than $80 and more than $70 on the average $75, making altogether a loss of	75
1 that does a damage of less than $90 and more than $80 on the average $85, making altogether a loss of	85
2 that do a damage of less than $100 and more than $90 on the average $99, making altogether a loss of	198
100 Total	$916

If the insurance is 10 per cent of the value, the rate should be	$0.34
If the insurance is 20 per cent of the value, the rate should be	0.24
If the insurance is 30 per cent of the value, the rate should be	0.20
If the insurance is 40 per cent of the value, the rate should be	0.17
If the insurance is 50 per cent of the value, the rate should be	0.15
If the insurance is 60 per cent of the value, the rate should be	0.13
If the insurance is 70 per cent of the value, the rate should be	0.12
If the insurance is 80 per cent of the value, the rate should be	0.11
If the insurance is 90 per cent of the value, the rate should be	0.10
If the insurance is 100 per cent of the value, the rate should be	0.09[1]

[1] *Ibid.*, p. 85.

The rates in the second table were derived from the figures in the first in the following manner:

On the assumptions stated as the basis of the first table, if insurance equal to 10 per cent of the value of each house were carried, the insurance would be $10 per house, totaling $100,000. The companies carrying the insurance would pay all the losses not exceeding $10 or $164 plus $10 on each of the other 18 losses, $180, or a total of $344. This is equal to $0.34 per $100 of the insurance carried.

If the insurance were 20 per cent of the value of each house, the total insurance would be $200,000. The companies would pay all losses of $20 or less, the sum of the first two brackets in the first table or $248 and $20 on each of the other 12 losses, $240, or a total of $488, which is equal to $0.24 per $100 of the insurance carried.

The other rate items are similarly calculated.

that their costs are not increased in order to pay part of the share of those who do not carry a proper amount of insurance in relation to value.

The way to enforce such conditions is to attach a clause making the insured a coinsurer (*i.e.*, a fellow insurer of his risk) with the others to the extent to which he is short of the proportion of insurance to the value he should have to make his rate right. Hence the clause was called a *coinsurance clause.* It would say in substance:

> The insured under this policy must carry insurance to the extent of 80 per cent of the value of the property insured by this policy. If that amount of insurance is not in force at the time of the fire, it will be assumed that it was and that the insured as an individual insurer had issued a policy to himself for the difference between the actual amount carried and 80 per cent of the value of his property.

This sounds like compulsion, in order to increase the business of the companies. A clause substantially so phrased was in use for some time. It engendered much opposition and hostile criticism because the reason for the requirement was not understood. After various attempts at a more satisfactory clause the following form was evolved:

> This Company shall not be liable for a greater proportion of any loss or damage to the property described herein than the sum hereby insured bears to .... per cent (%) of the actual cash value of said property at the time such loss shall happen, nor for more than the proportion which this policy bears to the total insurance thereon.
>
> In the event that the aggregate claim for any loss is both less than ten thousand dollars ($10,000) and less than five per cent (5%) of the total amount of insurance upon the property described herein at the time such loss occurs, no special inventory or appraisement of the undamaged property shall be required.
>
> If the insurance under this policy be divided into two or more items, the foregoing shall apply to each item separately.

This has the advantage of not appearing to impose any obligation on the insured but merely defines the insurer's obligations. It is in use in New York and vicinity and is known as the *New York standard average clause.* It is embodied in many of the covering forms in that state where the rates are made in contemplation of a ratio of insurance to value equal to 80 per cent.

Since it cannot be known, if a loss arises, what the obligation of the company is until the sound value of the property is known, that must either be arrived at or agreed to before the loss can be settled. An appraisal or inventory of a large establishment is an expensive job. The cost might exceed the amount recoverable under a small loss. If the loss is less than 5 per cent of the total property, the reduction in liability of the company, because of too little insurance, cannot be great. Hence in such cases it is better for both to agree to ignore the test of appraisal or special inventory and take the value shown by the insured's books as the sound value. The second paragraph of the clause is designed to meet such a condition.

In some jurisdictions the rates are not so made but contemplate a lower ratio, for example 50 per cent. In such jurisdictions a percentage reduction in rate is allowed for the attachment of an average clause, and a form of clause is used naming such reduced rate as the consideration therefor. This is a *reduced-rate average clause.*[1]

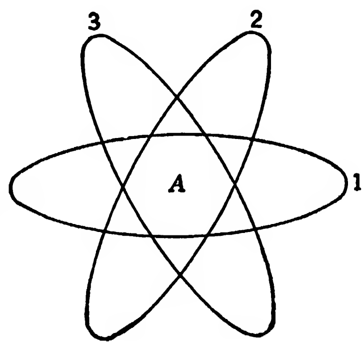

Fig. 1.

The equity of the clause is so little grasped in some states that its use has been prohibited by law. This is most unfortunate for it prevents a proper adjustment of rates to the conditions of the policy and usually results in the small policyholder's paying more than his fair share.

When such a clause is attached to a policy, there are, in addition to the limitation of the company's liability to the amount of actual loss sustained with due allowance for depreciation, three other limits. The company is not liable for more than (1) the face of the policy, (2) that proportion of any loss which the face of the policy bears to the total insurance, and (3) that proportion of any loss which the face bears to the named percentage of value stated in the average clause.

In any case, in insurance contracts or elsewhere where there

[1] Such a clause was formerly used on the Pacific coast, but it has now been displaced by an average clause substantially the same as the one quoted above.

are several limits or boundaries, the smallest or narrowest is effective. This must be so or one or more of the limits ceases to be a limit. This will become apparent by considering the limits of possible motion of a person at A in the diagram (Fig. 1) who is prohibited from passing beyond the boundary of any of the fences marked 1, 2, and 3, noting which one stops his progress in a given direction and how widely he could range were it not present.

The limit that is effective in any given case under an average clause may readily be found by constructing a diagram such as is shown in Fig. 2 for the most common case—an 80-per-cent average clause.

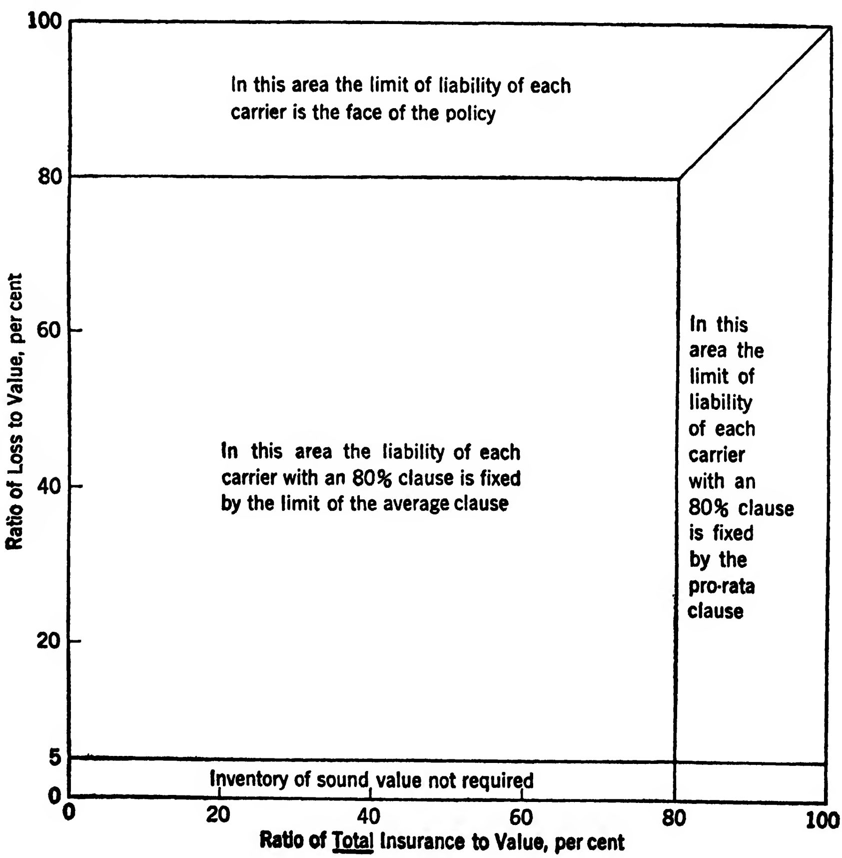

FIG. 2.

When the percentage of loss to value has been ascertained, the

ratio of insurance to value being known, the point of intersection of lines drawn through the two percentages parallel to the sides of the square will fix a point within it (or on its edge, if one ratio is 100 per cent). By observing the area in which the percentage of loss falls, the limit applying is found. If there are several policies and the limit named in the average clause is not the same in all policies, such a diagram would have to be drawn for each percentage named. The appropriate diagram should then be used for each policy.

Study of a few cases using such a diagram will show that if either the total insurance or the amount of the loss equals or exceeds the percentage named in the clause, the clause has no effect, a result consistent with the purpose of the clause.

ENDORSEMENTS DEFINING TYPE OF LOSSES COVERED

Business-interruption Insurance.—The fire-insurance policy is intended to cover only financial loss due to the value of physical property destroyed. Hence all the forms in use provide substantially, as does the one under discussion, that the loss shall be estimated "without compensation for loss resulting from interruption of business or manufacture." Yet, if real unforeseen loss is sustained in this way, it is a proper subject for insurance. In recent years this has been recognized and coverage for losses from interruption of business is offered. As it is a fire loss, most of the terms of the fire policy will apply, but other conditions are required to define the risk covered and to lay down necessary conditions.

If the risk is a manufacturing enterprise, a complete shutdown for a time will involve the loss of net profits and the payment of necessarily continuing charges to keep the staff from disintegrating, meet bond interest, and assure other conditions necessary to be able to resume. Such a loss is known as a "business interruption loss." It was formerly termed a *use-and-occupancy* (U and O) loss since it comes from the inability to occupy and use the premises. The latter term is still sometimes used. In the case of partial shutdown the loss involves some but not necessarily all of these items. By endorsement the coverage is changed from that of "direct loss by fire . . . to the following described property" as set forth in the standard policy to cover actual loss

sustained consisting of net profits on the business which is thereby prevented, such fixed charges and expenses pertaining thereto as must necessarily continue during a total or partial suspension of business, and such expenses as are properly incurred for the purpose of reducing the loss under the policy. It is necessary to use several forms[1] according to the degree of continuity in the operation of the risk and the desires of the insured as to the items of loss to be covered. Seasonally shutdown risks present special difficulties.

The form specifies the company's liability for total or partial suspension and defines a number of necessary terms. It requires the insured to resume operations as promptly as possible. Modification of the limitations of the basic policy by permits and restrictions may be included as with other forms.

When the operations of the insured are of seasonal or fluctuating character, a further problem is presented of providing an adequate amount of indemnity in the busy season without increasing the moral hazard by offering excess indemnity in the slack time. This is done by a form specifying a different maximum limit for each of the several periods.

Additional Charges and Expense Insurance.—Use-and-occupancy insurance is suitable for firms that can, if covered by such insurance, survive a shutdown period without permanent injury. But a business in a highly competitive field might not be able to suspend for a time without such loss of customers and connections as would practically force it to begin all over again. Such firms feel they must go on at any cost. For them there is offered insurance designated on the Pacific coast by the title of this paragraph. Elsewhere it is sometimes known by the shorter term extra-expense insurance. It is provided by an endorsement on a standard fire-insurance policy. The conditioning clause is, as in the use-and-occupancy form, damage to the premises during the term of the policy. The indemnity provision used on the Pacific coast is:

This policy being for $__________covers its pro rata proportion (namely__________ths) of the following: $__________on additional charges and expenses.

[1] See Appendix XI for one form covering manufacturing plants.

1. The conditions of this contract are that if . . . .

2. The amount of such additional charges and expenses shall be arrived at as follows:

Such fixed charges and expenses as must necessarily continue during a total or partial interruption of business; plus
Such additional charges and expenses as may be incurred for the purpose of maintaining and/or conducting the business of the insured;

The full sum of costs and expenses which would have been incurred in the normal conduct of the business had no fire occurred; subject, however, to the further conditions and limits hereof.

3. It is a condition of this contract that the liability of this company shall not exceed the following:

(*40*) % of the amount of the insurance hereunder for a "period of indemnity" of one month or less.
(*30*) % of the amount of the insurance hereunder for a "period of indemnity" exceeding one month but not exceeding two months.
(*20*) % of the amount of the insurance hereunder for a "period of indemnity" exceeding two months but not exceeding three months.
(*10*) % of the amount of the insurance hereunder for a "period of indemnity" exceeding three months but not exceeding four months.

In the event that the additional charges and expenses incurred by the insured during the longest period of restoration, for which provision is made above, do not exhaust the insurance hereby provided, then such unexhausted limit of liability shall apply for the remainder of the period of restoration, not exceeding in any event, however, 12 months after the date of the fire.

4. It is a further condition of this contract that, as soon as practicable after any loss, the insured shall resume complete or partial business operations of the property herein described and, insofar as possible, reduce or dispense with such additional charges and expenses as are being incurred.[1]

Additional Living Expense Insurance.—Occupants of a dwelling also may obtain insurance against extra expense by means of an endorsement on a standard fire-insurance policy. The endorsement sets up a total sum for the insurance. It specifies the "period of indemnity" as that necessary to restore the premises or until "the Insured's household becomes settled in any permanent quarters." The liability for any one month (30 days) during the period of indemnity is limited to 25 per

[1] The amounts entered in parentheses as percentages are commonly used.

cent of the amount of insurance. Thus, in order to be fully indemnified in all cases the insured must carry a total equal to four times his maximum extra living expense.

Profits and Commissions Insurance.—Profits insurance covers only the loss of profits on finished merchandise. Commissions insurance covers loss of commissions on sale of goods destroyed by fire. There is some justification for the question whether such insurance is consistent with the theory that the insurance contract is strictly one of indemnity. The values insured are not in existence and may never come into existence. Yet in modern life the prospect of such values is usually discounted in financial arrangements, and that prospect may be destroyed by fire. Profits have always been insurable in connection with marine risks. In all branches of insurance the acceptance of such risks must be attended with great caution for they present great opportunity for moral hazard. Considerable variation is found in the forms used.

Some companies have been willing to issue to large department stores of high reputation and unquestioned integrity policies providing for loss payment equal to the retail selling price of the goods destroyed. In such cases the profits are automatically insured, and separate profits insurance is unnecessary.

Rent, Rental-value, and Leasehold Insurance.—Corresponding to the loss which the manufacturer sustains by inability to use his premises and for which he is covered by use-and-occupancy insurance is the loss the landlord may sustain if his premises are rendered unfit for use and his income from rents is cut off. Insurance against this type of loss is known as *rent insurance*, and the form used is similar to that for use and occupancy though simpler.

The homeowner, if his house is rendered uninhabitable, must usually incur expense for rent until his house has been rehabilitated or rebuilt. This is in addition to his property loss. He may insure against this by buying *rental-value insurance.*[1]

If one is fortunate enough to own a leasehold on property in a neighborhood where rents have advanced since the lease was executed, he has a source of profit in the difference between the discounted value of the future rent at the rates likely to prevail

[1] See Appendix II, item 8.

during the remainder of the term of the lease and the discounted value of the payments required under his lease. Although this is a diminishing value, it is insurable under *leasehold insurance.* The form usually specifies the value of the leasehold and the rate of monthly reduction in the value. If the property is totally destroyed, the agreed value of the leasehold less the deduction for the elapsed time is payable. If the property is merely rendered uninhabitable for a time, the monthly indemnity is in an amount specified in the form.

Supplementary Insurance.—Persons whose property is insured under fire-insurance policies are also exposed to other insurable risks of loss of the same property. Until recently, if they desired insurance against such risks, it was necessary to secure one or more additional policies to cover against them. With the extended development of inland marine insurance the public has been offered in the *personal-property floater*[1] an "all-risk" coverage on property while "permanently located in summer, winter, or country home." This coverage has created serious competition for the fire-insurance business. In an effort to meet it, many fire-insurance companies are now offering a supplementary endorsement covering buildings and contents[2] against other risks which it is within their charter powers to cover. The additional risks usually covered under such endorsements are windstorm, hail, explosion, riot, and damage from aircraft and motor vehicles. A single additional premium is charged for this endorsement. The terms under which these risks are covered are substantially the same as those embodied in separate policies for such risks.[3]

The Dwelling and Contents Form referred to above and reproduced as Appendix II includes these risks and specifies the conditions under which they are covered and the additional premium charged for this supplementary insurance.

SUMMARY

In this chapter the principal clauses of the latest form of standard fire-insurance policy have been explained. The need of an extensive use of endorsements and riders to make the contract

[1] See p. 123.

[2] With some exceptions which it does not seem appropriate to deal with here in detail.

[3] See Chap. IX.

fit properly the needs of the public has been noted, and some typical examples of the more important classes of such riders have been examined. They have not been considered in detail as that could not be done adequately in a book devoted to a general consideration of all branches of insurance.

There are considerable differences in practice among the states, differences in the requirements of the several states making uniformity impossible. Policy forms and modifying endorsements are much alike, but the insurance carrier must always diligently examine the laws of each state (and the rulings of its insurance authorities) to be sure of complying with official requirements; and the insured must examine his contract with care in order to understand his rights and obligations.

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CHAPTER VII

MARINE-INSURANCE CONTRACTS

The field of marine insurance is that created by risks to which goods that may be in transportation and the means of transporting them are subject. Originally marine insurance was, as its name implies, confined to the coverage of the risks of ocean-marine transportation, but a natural extension has taken place, first to the coverage of transportation over inland waterways and then to that of transportation on land generally, even including transportation by mail.[1] The business has also been extended to cover certain, though not all, risks incidental to the construction of ships, known as "builders' risk." The great bulk of the business, however is in the coverage of the risks of ocean transportation.[2] Different forms are used for each type of coverage offered, but the key form from which all the others are derived is that designed to cover the ocean-transportation risk. Not only may risks to ships and cargoes be covered, but also risks to freights and profits. It is possible, without doing violence to the subject, to liken the coverage of the ship to that of the house

[1] By statutory enactment companies chartered and authorized to write marine insurance have been authorized to insure against "all risks" certain property in a fixed location, for example, art objects of high value for which full coverage could not otherwise be obtained except under several different kinds of policies and even then with the possibility of some gaps in the coverage. This seems to have been justified by the fact that such objects may at times be put on exhibition at places remote from their normal location, which would require their transportation and thus bring them within the marine field. Even though such exhibition were infrequent, it might be upon short notice. From this small beginning the list has been considerably extended, including even such things as ornamental glass (church) windows, provided they are of such fine quality as to be properly classified as works of art.

[2] The growth of inland marine insurance in the United States has been very rapid in recent years but has not yet overtaken the true ocean-marine volume.

against fire; the coverage of the cargo to that of the contents of the house; and the coverage of freights, profits, etc. to the similar coverage in fire insurance known as "use-and-occupancy insurance."

Historical Development.—Marine insurance is the oldest branch of the insurance business. No record of an insurance business in the modern form among the ancients has come down to us, through respondentia loans served in a limited way to perform the same economic function. These loans were made on the security of the venture and were repayable with interest if the voyage was successfully completed, but were canceled if it failed. If the lender negotiated a sufficient number of such loans, he had a more or less regular ratio of loss, and a part of his interest was in the nature of an insurance premium to pay losses.

The precise time and place of the origin of marine insurance in the modern form is unknown, but it is generally agreed that it was prior to A.D. 1400 and among the Lombard and Venetian traders in the Mediterranean. It is certain that it was brought to London by the Lombard merchants, and the name "policy" (from *polizza*—a written and folded document) given the written insurance contract is evidence of its Italian origin. The early business was not done by corporations as now, but by individual insurers. The proposal was presented at a common meeting place of traders; those willing to accept part of the risk attached their signature at the bottom and indicated the amount they assumed with notations of any further limitations that might be agreed to. From this practice comes the term "underwriter" which designates one who is skilled in passing upon the desirability of accepting particular risks and the proper terms of acceptance.

At a somewhat later time the coffeehouse of one Edward Lloyd was a congregating place for those interested in seafaring ventures, and a center of marine news. It became a headquarters for those traders who were disposed to become underwriters of marine risks. Gradually, as the volume of such transactions increased, a few, and later an increasing number, gave up their other trading to specialize in underwriting. In 1769, an organization of the underwriters at Lloyd's, London, was formed,

which persists to the present time and does business in much the same way as in the olden days at Lloyd's coffeehouse, though in more businesslike surroundings. As would be natural under such circumstances, the form of policy for covering the cargo risk was gradually standardized, until the underwriters adopted and printed a standard Lloyd's form of contract in 1779. Through the decision of innumerable cases since that time, every phrase and word of this old contract has received the attention of the courts, with the result that, at least among English-speaking countries, the old contract is the core of all marine-insurance policies; this despite its archaic language, which to a modern is almost meaningless jargon. The modern American policy[1] does not rigidly follow the old form, but its outstanding features are the same. Before undertaking a study of the form, an explanation will be given of certain conditions attending the conduct of the marine-insurance business, which are not found in other kinds of insurance and which sharply differentiate the forms and practices in marine insurance from those in the other branches.

Competitive Character of Marine Insurance.—The cost to the consumer of a product is not its cost in the primary market for that product, but the cost at that point plus all the costs involved in its transportation to the point of consumption. As a concrete illustration, the cost to a Liverpool cotton merchant of a consignment of cotton purchased in the New Orleans market may be taken. He must resell that cotton at a price which will reimburse him for that cost including what he paid in New Orleans for the cotton itself, for the freight he paid, and for insurance during transportation, as well as all other expenses involved in landing the cotton at Liverpool. To the extent that the Liverpool price exceeds the sum of these costs he will make a profit. He will, therefore, do his utmost to keep these costs at the lowest possible point.

If there are reputable underwriters in New Orleans who are offering insurance of cargo at a rate as low as, or lower than, can be obtained elsewhere, he may well buy in New Orleans c.i.f. (cost, insurance, and freight); meaning that the price paid includes these charges. But if there are underwriters in Liver-

[1] See Appendix XIII.

pool, London, or, for that matter, Zurich, or Bombay, in whose financial standing he has full confidence and who quote a lower rate, or otherwise offer more favorable terms, he will buy f.o.b. New Orleans and negotiate his insurance in the most favorable market. In international trade the buyer, who pays the bill, is not a resident nor, usually, a citizen of the country in which the cargo originates, and is therefore not amenable to its laws, except as it may be possible to reach him through his goods. Were Lousiana to impose restrictions on the shipment of cotton overseas except under certain prescribed conditions as to insurance, it could only do so at the jeopardy of its trade. As the buyer, the one who would suffer through bad insurance, is not a local citizen, there is not the incentive to surround his contract with safeguards. If he takes his insurance in his own country, he will receive the benefits of its law but, if he goes abroad for his insurance, he is not followed by the same safeguards. He would be protected only by the laws of his own country which would not protect him elsewhere. Under such circumstances, the marine-insurance business is internationally competitive, and there is considerably less standardization of forms or practices by statute than in other lines.

Because of the prominence of Lloyd's underwriters during the days of the growth of British trade, the immense overseas trade of Great Britain, and the importance generally of London in international trade, London and Lloyd's are still the world center of marine-insurance activity.

In 1906, Parliament passed "An Act to codify the Law relating to Marine Insurance."[1] The first schedule of this act reproduces the Lloyd's policy as the one to which the act applies, but the form is not made mandatory. Indeed, a part of the same schedule reads, "The following are the rules referred to by this Act for the construction of a policy in the above or other like form, . . . " which clearly implies permission to use other forms.

Notwithstanding international competition which wholly precludes any concerted action in regard to rates, so great is the body of law built up around the old Lloyd's form, and such is the value attached to this interpretative work, that even the forms

[1] 6 Edw. 7, Ch. 41.

used by American insurance corporations are, in their important terms, substantially in that form.

Marine Policy Forms.—Even more than with the standard fire-insurance policy, it is essential, in marine insurance, to use endorsements to fit the contract to the needs of individual risks, though different policy forms are used to cover the distinctly different marine lines. The extent to which different forms are used for different kinds of risk varies from company to company though certain distinct classes are found with all companies. The most important types are

Cargo policies covering goods in transit in vessels.

Inland transportation policies covering goods in transit by rail or inland water carrier.[1]

Mail policies covering shipment of goods or securities (registered mail policies) sent by mail.

Tourist floater policies covering personal effects while traveling.

Hull policies covering vessels and their equipment.

Freight and profits policies covering freight charges and profits of vessel owners and shippers.

Builders' risk policies covering the risks of construction and testing (trial trips) of vessels.

Liability (protection and indemnity) policies covering liability for injury to the person or property of others due to the operation of vessels.

The basic form[2] will first be analyzed, after which the purpose and significance of the more common types of endorsements will be explained. This procedure will be applied to the cargo form as a type; variations from this form will be indicated under appropriate headings. There will be considered in order:

1. Parties.
2. Consideration.
3. Risk transferred.
   a. Property covered.
   b. Term.
   c. Hazards.
4. Loss procedure provisions.
5. Limitations and qualifying clauses.

[1] Different forms are used for motor-truck transit than for shipment by other means.

[2] See Appendix XIII.

The Parties.—In America the policy is regularly headed by the name of the insurer. Where the insurance is written individually by a group of underwriters, as in the case of policies issued at Lloyd's, London, it is obviously impossible so to head the policy. Since the policy must be properly signed on behalf of the insurer, this heading appears to have no legal significance. The name of the insured taking out the policy appears next, followed by the words "on account of," after which is a space in which is to be written the name of the party for whose benefit the insurance is taken, the real insured. This may be the person taking out the insurance, in which case the blank would be filled out "himself." Generally this is not the case in cargo insurance, the insurance being taken for the purchaser of the goods shipped. As was indicated in Chap. V, a real insurable interest is necessary to the validity of any insurance contract, but there may be a variety of interests in a marine venture, such as those of the owner, managing owner, mortgagee, consignee, factor or commission merchant, trustee for creditor, or agent, all of which are valid and insurable to the extent of their actual value. The party for whom the insurance is effected, if known, and the nature of his interest should be clearly indicated.

Goods are often sold while in transit. Sometimes ownership changes hands several times, and it may not be known, when the insurance is written, who is to have the protection of the insurance at a particular time in the future. In such cases it is customary to fill in the blank with the phrase "whom it may concern." This is not all-inclusive but implies only that class of interests for whom the named assured is acting, and only those of such class who may have authorized him in advance to act as their agent for that purpose or who may afterward ratify his act and adopt the insurance. Ratification need not necessarily have taken place before a loss.

The policy designates the currency in which, place at which and person to whom the loss is to be paid. The payee may be the real insured or some interested third party. If the shipments are financed by a bank, it is customary to make the policy payable to the bank to protect its advances. Since the interest of the underwriters cannot be adversly affected by the arrangement to pay some other party, if that party can give a valid

release from liability on payment, it is quite in order for the insured to order payment to someone else, and for the insurer to accept and act on such order.

Consideration.—The marine policy does not, like the fire policy, recite the consideration at the outset. It will be noted that toward the middle of the policy there is a blank space preceded by the words "having been paid the consideration for this insurance, by the assured or his or their assigns, at and after the rate of . . . " At this point is entered the premium rate, which, as far as the policy itself shows, is the sole consideration. This language does not make the policy itself a receipt for the premium but has been held to be merely a statement of what the underwriters are entitled to receive. Similar, but stronger, language in the Lloyd's policy has been held only prima-facie evidence of payment. By implication and construction, other considerations in the nature of representations and warranties have been read into the contract.[1]

Risk Transferred. *Property Covered.*—The printed form apparently covers "all kinds of lawful goods and merchandises laden," etc., but the actual coverage is not so broad. Except in blanket policies, which will be further discussed later in this chapter, it is customary to write a description of the specific property insured immediately before this phrase. In this description it is desirable to identify the goods by specific marks as, for example, "100 cases canned asparagus, marked Livingston, Brown & Co. XXX."

The policy form identifies the goods as "laden or to be laden." As will be plain when the term of the coverage is reviewed, this language does not cause the insurance to attach until the goods are loaded, but refers to the condition of the goods at the time the policy is negotiated. Commercial necessity dictates that the goods must never be left unprotected. Hence the policy should be negotiated before the loading so that it may take effect as to each piece of property as soon as it comes within its scope. This language defines the class of goods to be covered, *viz.*, those to be taken on the ship named in the policy.

The policy provides space for naming the vessel and its master, though it provides also for the possibility of the vessel sailing

[1] See p. 56.

under a different name or a different master. The fitness of the vessel for the contemplated voyage is a most important consideration for the underwriter in determining the acceptability of the risk. It is therefore of the utmost importance that the vessel be correctly identified and, if this be accomplished, it is immaterial if the name is changed. This provision will not save one who misrepresents the vessel involved, but if the name is changed and both parties correctly understand the identity of the vessel, the policy holds. A consideration to the underwriter scarcely second to the fitness of the vessel, is the skill of the master, and it was formerly important that the exact facts as to who was master be communicated. With the growth of shipping since the First World War, it has not been possible to follow this so closely. Usually now this blank is not filled in and some companies omit from their policies any reference to the master.

The policy provides that "the said goods and merchandises, hereby insured, are valued (premium included) at . . . ." Since the purpose of transportation is an increase of value of the goods transported, the goods on arrival will, in general, be worth more than on departure. If lost in transit, serious dispute might well arise over the value at the time lost. This problem, difficult as it would be in modern times, was far more difficult in the early days of marine insurance when long slow voyages and the small carrying capacities of vessels made the transportation costs, and consequently the spread of value between point of embarcation and destination, much greater than at present; and the lack of rapid communication caused much more difficulty in fixing the time of loss. So the custom of specifying the value in the policy early became established. Marine policies have always been written on the basis of 100-per-cent coinsurance; if the insurance does not equal the value stated in the policy, the underwriter bears no larger proportion of any loss than that which the amount of the policy bears to the stated value.[1]

In the case of partial loss (the only case to which coinsurance conditions apply) the practice is to ascertain the market price at the place of destination and time of arrival of undamaged goods

[1] Although not specified in the policy, this practice has been recognized in common and statute law.

of the same kind and quality. Then the price that the damaged goods would bring in the open market is found, often, if not always, by their actual sale. The difference (the amount of loss) is expressed as a percentage of the sound value. The amount paid is that percentage of the value stated in the policy. For example, if a cargo were shipped with a stated value of $1,000 and sustained damage on the voyage, it might bring $600 on arrival. A quantity of similar goods equal to that shipped might be worth $1,200. There would thus be established a 50-per-cent loss of value. Fifty per cent of the named value of $1,000, or $500, would be paid. The insured would sustain an uninsured loss of $100, the proportion of the loss which his declared value was short of the true value. In the rare case of overvaluation, the insured, under this practice, receives more than his loss by the proportion of his overvaluation. If the market value of sound goods in the above case proved to be only $800, the loss in value of $200 would have been 25 per cent and the amount paid $250.

Term of the Contract.—To meet the needs of commerce and trade a variety of marine-insurance contracts are used, even to cover the cargo risk alone. The large shipper, for example, will usually take a blanket policy covering all his shipments for a term (usually one year) specified in the contract. Provision is made under such a contract for the issuance of certificates covering each reported shipment. For the small shipper *voyage policies*, covering individual shipments, are issued. Originally all policies were voyage policies, and the certificate covering an individual shipment under a blanket policy is in effect a voyage policy. The basic form is prepared for this type of coverage, and the term of the policy is the voyage. It is described in the space provided therefor, beginning with "at and from . . ."

As indicated in the form, the risk begins as soon as the goods are loaded at the initial terminus (the *terminus a quo*), and continues until safe landing at the final terminus of the voyage (the *terminus ad quem*). The point of time at which the goods are "loaded" depends on the custom at the port of departure. If the loading is done from dock cranes, for example, the risk does not attach under the policy until the goods are deposited on the deck or in the hold of the vessel. If the custom is to

load by the vessel's slings, booms, and other gear, the risk attaches as soon as the goods clear the wharf. In landing, the termination of the risk depends on what is customarily accepted at the destination as safe landing. If transfer to a receiving barge is the accepted custom, the risk ceases when the goods are deposited on the barge, but if the custom requires transfer to surf boats and landing on the beach beyond the surf, the risk continues until this is accomplished.

It is an implied warranty, read into the contract by the courts in a long line of decisions, that, unless otherwise specified in the policy, the voyage will be by the shortest customary route and that it will be prosecuted without delay. Failure to comply with these implied warranties constitutes a *deviation* and renders the policy void. But the policy by its terms permits one type of deviation, *viz.*, that made necessary by stress of weather or unavoidable accident. Universal and time-honored custom of the sea permits one other deviation, the errand of mercy to save life. But deviation to salvage goods is not permitted by custom. It is now usual for a clause to be added permitting deviation subject to adjustment of premium.

The insuring clause contains the words, "lost or not lost." Even though the vessel were lost at the time the policy was issued, if that fact were unknown to the insured or insurer, though perhaps suspected by both, there would be no inequity or impropriety in issuing a policy; and many policies, particularly of reinsurance are so issued. In this way probable loss may be spread over several insurers at appropriate rates.

Hazards Covered.—Two points are outstanding in the description of the hazards covered in the marine policy: first, the broad inclusiveness of the *perils clause* in which it appears, from the order of the terms, that efforts have steadily been made to cover any reasonable risk which may arise in a voyage, and that, as risks came up which were found not covered under the form of policy in use, the policy was modified to include them; and second, the freedom of the policy from clauses limiting the insurer's liability. There are only two such clauses in the basic Lloyd's form, the *sue-and-labor clause* and the *memorandum clause*, and the companies rarely print more than one or two more in their policies, though it is common practice to attach limiting clauses

by endorsement. But such is the simple character of the basic policy and so free is it of conditions that these limiting endorsements, even in the harsh form of warranties, are still given full force by the courts, as are the implied warranties of non-deviation and of seaworthiness. Indeed, one eminent insurance lawyer raised the question before the Insurance Society of New York,[1] whether the fire underwriters might not have done better for themselves had they drawn less complex forms and relied on the courts for fair treatment. The coverage of the perils clause is not so broad as a first reading appears to indicate, but the explanation of its limits would lead too far afield.[2]

The sue-and-labor clause is both a restriction and an extension of the coverage. It arises out of the peculiar hazards of marine enterprises. If, for example, a vessel is in collision with another in foreign waters, it may be desirable to bring action promptly against the other vessel in order to protect the right of recovery. If it is stranded, it may be necessary to incur expense for the protection of the vessel. It is desirable in the interest of the insured and insurer alike that the loss be minimized. Yet the insured will be loath to spend money for these purposes unless assured of reimbursement and, even then, not unless it were clearly his duty to do so. This clause makes it the duty of the insured or his representatives so to do and guarantees that he will be reimbursed.

For an understanding of the second limitation, in the memorandum clause, it is necessary to understand two technical terms of marine shipping practice and their origin. It has been the custom of marine traders from the earliest time to apportion a sacrifice made of one interest in a venture for the common good ratably among all the interests affected. Since the loss is general, its settlement is known as a *general-average adjustment*, and the loss that gives rise to it, as a *general-average loss*. When partial loss occurs to a particular interest and does not result

[1] See Richards, George, "Fundamentals in the Law of Insurance and Why Adopted," in "The Fire Insurance Contract," pp. 72–83, especially pp. 82–83.

[2] A more complete discussion of the perils clause will be found in William D. Winter, "Marine Insurance," Chap. VIII; S. S. Huebner, "Marine Insurance," Chap. V.

from a sacrifice for the safety of the entire venture, the loss is a *particular average*, and that interest and its insurer alone bear the loss.

An example will help clear up the meaning and effect of these terms. If, in a mixed cargo, including copra from the Philippines and silks from China among other things shipped to San Francisco, the copra takes fire while on the voyage, and in the course of putting it out, the silk is water-damaged, the copra has suffered a particular-average loss (for the loss was sustained by it but in no way as a sacrifice for the common good), while the silk has sustained a general-average damage, since the water was used to put out the fire and save the entire venture.[1] The problems of adjusting and apportioning general-average loss are so intricate that there has grown up a special profession of marine general-average adjustment, and even skillful marine underwriters do not undertake this apportionment.

There is always a certain amount of breakage in the shipment of goods, especially by water, owing to the motion of the vessel. Some goods also are particularly perishable if subjected to undue heat or moisture, both of which may be found in the holds of vessels. If these risks are covered under the marine policy, the amount of losses the underwriters may be called upon to pay will be much larger than if they were excluded. Premiums will have to be higher to correspond. The man who is making many shipments during a year will sustain a certain regular loss from this cause just as would the insurance company. Since these losses are regular rather than uncertain, there is no appreciable risk, and they may well be treated as a part of operating costs. There is no gain to a shipper in having these risks covered by his insurance. Rather there is loss since the premium may be expected to provide not only the amount to pay the losses but something in addition for expenses and profit to the underwriter. The covering of such losses is also an annoyance to the underwriter since the expense of settlement would often exceed the amount of the loss. Such considerations long since led to the addition of the memorandum clause reducing the liability of the underwriter for particular average to certain classes of goods. The amount of particular average excluded from the policy for

[1] See York-Antwerp Rules, 1924, Rule III. So also under 1890 rule.

each class of goods is set up in the clause and depends on the susceptibility of the goods to such damage.[1]

Loss Procedure.—The policy is free from detail as to loss procedure, the only reference being to the time within which the loss is payable and the respective liability in the case of several policies. But custom has established a definite loss procedure which now has the force of law. Owing to complexity of apportioning general-average loss, it is usual for both the insurer and the insured to resort to professional adjusters to determine the amount and validity of claims.

This simplicity in form may be contrasted with the elaborate specification of proofs and procedure for loss settlement under the fire policy. The marine policy refers to these things only in an incidental way in fixing the time when payment must be made by the insurer, but the furnishing of such proof is implied in the policy and required generally in law to sustain a claim.

Total Losses.—One of the tragedies of the sea is the necessity at times of abandoning the ship to save life, either at sea or after stranding. The sue-and-labor clause requires the insured to make every reasonable effort to save property, but such efforts should not be pushed to an unreasonable extreme, for cases might well arise where they would endanger the lives of all on board or where the cost of salvage would exceed the value of the thing saved. Clearly this would be waste and would justify abandonment of the venture and the making of a claim for total loss. Whether the abandonment is physically necessary to save life or merely financially advisable because of salvage cost, the insured property becomes the property of the underwriters. Where the abandonment is not for physical reasons, it is referred to as an abandonment to the underwriters who in such cases are usually on the ground and take charge. A total loss by abandonment is known as a *constructive total loss* to distinguish it from *actual total loss*. Both British and American law recognize constructive total loss, but the rules differ. Under the English rule, such total loss may not be claimed unless the cost of salvage or repairing equals, or exceeds, the value of the vessel when repaired; under the American rule, the vessel

[1] For form of clause see Appendix XIII, Memorandum.

or goods may be abandoned if the cost of salvage and repair will equal or exceed 50 per cent of the repaired value. These rules are not directly stated in the policies in use in either country but are implied by the fact that policies are subject to the laws of the country where issued.

Other Insurance.—The policy provides against excess recovery where there is more than one policy covering the risk, but in a quite different way from the fire policy. Under the marine policy as issued by American companies, the insurers pay in order of the date of the policy and, if a company is exempted from part of the claim because of prior insurance, it is bound to refund the premium for that part of its insurance from which it is exonerated.[1] Only in the case of concurrently dated policies is the rule the same as in fire insurance. The Lloyd's (British) policy contains no reference to other insurance, but the marine-insurance law holds the underwriters liable pro rata. The effect is that the insured may claim against any of his policies, and the insurer paying the loss may then seek reimbursement from his coinsurers pro rata.

Cancellation.—The nature of the risk with which marine insurance is concerned is such that it would be inexpedient and inequitable to grant to the insurer the right of cancellation once it is in effect. If he had a right to cancel, he might do so when he learned of storms or other trouble on the route or voyage proposed. The insured would then be exposed to the very type of risk he insured against and could probably not replace his insurance except upon less favorable terms. If it cannot be granted the insurer, it should not in equity be granted the insured. Otherwise he might cancel if conditions became more favorable and he could get insurance elsewhere at less rate. Hence, there is no provision for cancellation in the marine-insurance policy nor for any return of premium, even if the policy is issued after the voyage and risk have terminated. If the fact of such termination was known to the insurer and

[1] If, for example, the value of a vessel were fixed as $100,000 and when $80,000 insurance was in force an additional policy of $40,000 were issued, the company issuing it would be liable for only one-fifth of the loss and be bound to return one-half the premium it charged, *i.e.*, the premium on the $20,000 insurance under which it had no liability.

not disclosed, there would be fraud in the transaction and the premium would be recoverable. Since the basic contract may be, and is, freely modified by endorsement, the policy may be made cancelable by the terms of an endorsement, so that when such a right is necessary to a fair and equitable contract, as in the case of a term policy on a Great Lakes vessel which lies up a considerable period each winter, it may be granted.

Modification of Policy by Endorsement.—Probably no basic insurance-policy form is so frequently or so widely modified by endorsements as the marine contract. The great variety of risks covered in cargo insurance alone, both those created by the susceptibility of the goods to damage and by their causing fire or other damage and those due to the ship and voyage, and in addition differences in commercial customs, make it necessary to be able to give the contract an almost individual form for each risk assumed. This can be done only by writing individual contracts (an insufferable burden) or by the use of a varied assortment of endorsements. Though the latter course creates its own problems, it is the easier way out.

Despite the numberless forms of endorsement, there are many so common as to have become substantially standardized. Several of these will now be discussed as examples of types.

Clauses Enlarging the Risk Covered. *Extending the Term (Voyage) Covered by the Policy.*—Frequently, it is the desire of the shipper to cover goods by the policy from the time they leave the warehouse to go to the ship until they arrive in the warehouse of his consignee at the point of destination.

There is, of course, an insurable interest in the goods during the entire period, and they are exposed to various perils which might cause their destruction or damage. The *warehouse-to-warehouse clause*[1] is a legitimate extension of the marine coverage although it involves the hazard of land as well as sea transportation. It provides that the insurance attaches from the time the goods leave the shipper's warehouse and continues during the ordinary course of transit until deposited in the warehouse at the destination named in the policy or clause.

Risk after Discharge.—Since the basic form covers only until goods are safely landed, it is customary, where the insured

[1] See Appendix XIV.

desires and will pay the proper premium, to extend the policy by endorsement to cover the risk on wharf for a certain number of days after landing.

Adding Hazards.—The marine policy is so broad in its coverage that there is little need for adding clauses to extend its scope. The most serious limitations on the underwriters' liability arise from the implied warranty of no deviation which includes prompt sailing. Either of these requirements may be waived by endorsement. Additional hazards, such as of sweating, mold, breakage, or leakage, are also often assumed by endorsement.

The modern policy having had the war risks eliminated from its general scope, these can be covered only by adding a clause assuming the war risk.

Mortgagee Interest.—After the First World War there were many losses where it was suspected (and sometimes proved) that the vessel was "cast away" at the behest of the owners.[1] In one such case, that of the steamer *Gregorios*, it was held that the vessel had been lost through the intention of the owners and not through an insured peril. In this case there was a mortgage on the vessel, and a claim was made on behalf of the mortgagees that since they were innocent of wrongdoing they should still be permitted to collect. It was carried to the House of Lords which decided adversely to the claim. This decision led to the adoption of a clause for protecting such interests, when present, against loss due to the wrongful act of the owners.[2] The reasons justifying the use of such a clause are similar to those underlying the use of the Standard Mortgagee Clause on the fire-insurance policy.[3]

Reducing the Risk Covered.—Since the rate must, of necessity, depend on the risk assumed, elimination of any part of the risk tends to a reduction of the premium, and various clauses, usually in the form of warranties, are added for this purpose. If the underwriter is unwilling to assume a particular type of risk at any price because of the friction that might result in adjustment

[1] It should be remembered that the marine policy is a *valued policy* and, if the value had depreciated and the insurers were not able to prove fraud, the owner might profit by his loss.

[2] See WINTER, *op. cit.*, p. 157.

[3] See p. 88 and Appendix V.

of losses, or for any other reason, it may be excluded in the same manner. Of particular importance in this class of clauses, because of its common usage, is the *F.P.A.* (*free-of-particular-average*) *clause.* The underwriter may not wish to cover the partial loss (P.A.) owing to poor packing or a variety of other conditions. Yet he is quite willing to assume the risk of partial loss due to a general peril such as burning, sinking, stranding, or collision. Two common clauses are in use, one drawn by American underwriters, the other by English, and designated respectively as the *F.P.A.A.C.* (*American conditions*) and *F.P.A.E.C.* (*English conditions*) *clauses.*[1] The American clause reads simply, "Free of particular average unless caused by stranding, sinking, burning, or collision with another vessel." The English clause in its simplest form reads, in part, "Free of particular average unless the vessel or craft be stranded, sunk, burnt, or in collision." The original intent was probably the same, but the courts have construed the F.P.A.E.C. clause to cover particular average if the excepted general cause (stranding) has been present during the voyage though having no connection with the loss, for example, scraping the bar (a technical stranding) on leaving a harbor. The American is not so construed.

The First World War gave rise to a considerable number of unusual hazards such as the interest of an alien enemy in the enterprise with consequent loss of the venture in a prize court, likelihood of abandonment of defense in event of capture and taking into a prize court, etc. Numerous warranty clauses have been used to exclude such risks.

Other Types of Modification.—The most common clauses in use are of one or the other of the above types, but other clauses are used to meet the need of particular circumstances. Probably most common of these is the *P.P.I. clause.* Ordinarily, loss is payable on proof of loss and interest. Sometimes, as in the case of freight or charter fees, it may be difficult to prove the interest of the insured, though the interest may be real and insurable. It is then customary to endorse the policy, *policy proof of interest,* and the insured is not then required to present further proof of his interest. Another clause of the same purpose is the *F.I.A.* (*full interest admitted*). These clauses are not enforceable in

[1] See Appendices XV and XVI.

court but are matters of honor and agreement between gentlemen. They are scrupulously respected. Of course, the underwriter must be most cautious and sure of his man before he attaches such a clause.

Floating and Blanket Policies.—Large importing and exporting houses have many shipments at sea at all times, and sometimes are not notified of them until a consignment is ready to sail or has actually sailed. To procure individual policies would be difficult and would involve serious delay. To avoid this such houses usually carry policies either in the *floating*, or *open*, or *blanket* form. In either case, the policy in its essential points is the same as the form previously considered, though the term is usually for a fixed period. In the case of floating policies it may be indeterminate.

Under the floating or open[1] form, the insured is covered for all his shipments within certain geographical limits, with the proviso that the maximum liability for a particular shipment shall not exceed a fixed sum. He is required to declare such shipment as advices are received, and pay the corresponding premium. The advantage of the policy to the insured is that he is covered even though the loss occur before he declares the shipment. The underwriters, in issuing such a policy, place confidence in the honesty of the insured, since he may fail to declare shipments where there has been no loss and would hardly be likely to omit such declaration where loss had occurred. Thus the underwriter would have his premiums diminished without reduction of his losses.

Under the blanket policy the total volume of shipments of the period is estimated in advance, and the premium paid in a lump sum. Sometimes the premium is subject to adjustment at the end of the term, based on the actual shipments using the named rate. In other respects it closely resembles the floating policy. The tendency is to confine this form to local coastwise shipment and not use it for intercoastal or overseas coverage.

[1] These terms are used alternatively to describe the same form, though in a broader sense the term "open" refers to a policy any of whose terms are not completely stated; for example, a policy on a specific risk where the amount required had not been determined at its date of issue and which therefore requires a supplementary agreement to define completely its terms.

Under both of these policies the insured is authorized to issue certificates and thereby change the payee as may be necessary. The representative of the insurers countersigns these certificates and, in present practice, the certificate is much more often the document that accompanies the bill of exchange and the bill of lading than is the policy. The term of a blanket or floating policy is automatically extended to the completion of all voyages covered by it.

Hull Coverage.—The insurance of the vessel is known as "hull insurance." The policy covers not merely the bare hull, but the ship, its machinery, and entire equipment.

The policy is an adaptation of the basic policy which has been discussed. The most important differences are

1. It usually covers a fixed term rather than a voyage, and therefore provides for cancellation by mutual consent and for refund of premium at a rate specified. It also provides for refund for periods of idleness when the risk is much reduced.[1]

2. It provides coverage of the liability of the owners of the insured vessel to indemnify the owners of the other vessel if the insured vessel were at fault in a collision. Provision is also made for settlement of the complicated questions arising in case of inability to agree on the loss in certain cases.

3. In place of the memorandum clause is a special clause applicable to each voyage excluding particular average of less than 3 per cent or a fixed amount as £1,000 or $100 or $500.

4. It contains a provision that, if the vessel is at sea when the term of the policy expires, the policy is extended at the same premium rate pro rata until she reaches her destination.

The equity of this clause is apparent. It is not included in a fleet policy covering a large fleet which would probably have one or more vessels at sea whenever a policy might be written. Under such conditions the underwriter accepting the risk for a new period would not be so reluctant as in the case of a single vessel at sea.

5. It contains a clause exempting the insured from the consequences of breach of warranty regarding cargo, trade, or similar

[1] Voyage hull policies are also issued on "tramp" vessels but, as such vessels are more and more coming to be replaced by regular liners, the voyage hull policy is less important.

hazard, provided notice of such breach is given the underwriters and the required premium paid.

6. It usually contains a clause providing that the English rule of constructive total loss shall apply.

Though there is not so frequent occasion to modify the hull policy by endorsement, it may be done in the same general manner as in the case of the cargo policy.

Builder's-risk Coverage.—There are many risks to which the builder of a ship is subject during the course of construction and on the trial trip and against which he requires insurance. This is written by marine underwriters under a *builder's-risk* form.

Under this form,

1. The risk begins from the laying of the keel and continues for a fixed term unless the vessel is delivered before that date when the policy is terminated and a refund made, and it may be extended to the completion of the vessel if the term expires before then.
2. The perils clause is the same as in the basic marine-cargo policy and includes the sue-and-labor clause.
3. The collision clause is the same as in the hull form.
4. The *protection-and-indemnity* clause assuming the loss which may be imposed by responsibility for damage to property of others is included.
5. Liability is not assumed for losses due to
   a. Injury of workmen and the consequent liability of the insured under workmen's compensation laws or employers' liability, or legal responsibility for accidents to other persons.
   b. Strikes, riot, and civil commotion.
   c. Earthquake.
   d. Damage of materials of construction or equipment in transit before reaching building port.
   e. Consequential damage or claim through delay, regardless of cause.

Protection and Indemnity.—The shipbuilder is not the only one to require protection against loss that he may sustain through being held liable for damage to the property of others. The ship operator also requires protection, as well as protection

against being held responsible for personal injuries to his crew or others. This may be furnished by a clause attached to the hull form covering the liability of the insured to pay damages for

1. Loss or damage to any other boat or its cargo.
2. Loss or damage to other interests.
3. Loss of life or personal injury.
4. Loss or damage to any harbor, dock, or similar facility or structure.
5. Loss or damage caused by salvage efforts if the vessel is wrecked, or loss or damage caused by the failure to salvage.

Of course, this clause covers only the liabilities indicated when they arise from the ownership or operation of the vessel or vessels insured in the policy to which it is attached.

Usually these risks are not carried by such endorsements, but in separate policies issued by a mutual organization known as a "club" or "association." The risk transferred under the separate policies, however, is as indicated above.

Inland Marine Insurance.—The warehouse-to-warehouse clause extends the coverage of the ocean-marine policy to include certain land risks. Insurers of marine risks also issue contracts covering the risks of inland transportation, whether by rail, motor vehicle, express, parcel post, or registered mail. The increase in the amount of traveling done by all classes of people and the greater values in furs, jewels, and other property carried by travelers have created a growing demand for *floater* policies to cover various kinds of property exposed to risk elsewhere than at the residence or place of business of the insured. The policies provide all-risk coverage such as is furnished by the marine policy. Marine underwriters have extended their activities to cover this field and have built up an extensive business. They have developed a numerous and varied set of policy forms for a full analysis of which the student is referred to writers dealing especially with that field.[1] Their terms are not quite so brief as those of the marine policy nor so extended as those of the fire policy. Some of the clauses seem to have their origin in the marine policy and some in the fire policy.

Floaters fall into two main classes: those covering property

[1] See, APPLEMAN, EARL, "Inland Marine Insurance," Chaps. II–VI.

used in the insured's business or profession and those covering property of an individual used for his personal convenience or enjoyment. This extension of the marine-insurance field began with the former, though both groups have been continuously and rapidly extending.

Commercial Floaters.—In the former group are the commercial traveler's policy, formerly known as the "drummer floater," covering samples of merchandise in trunks and other shipping packages carried by him; the theatrical floater, covering scenery, costumes, and theatrical properties (excluding buildings and like property not taken along with traveling troupes); the horse-and-wagon policy; the jeweler's block policy (one of the most important of the floaters); the physicans' and surgeons' policy, covering their surgical and scientific instruments, "during transportation or otherwise, including in the residence of the insured," against loss "however caused" with some unimportant exceptions; the radium floater and some others.

The *jeweler's block policy*, because of the high values involved, is very carefully drawn. The consideration clause mentions not only the stipulations and conditions and the premium, as in the fire-insurance policy, but also a written proposal and declaration. The proposal and declaration contain many statements about the insured's business which are made a part of the policy and warranted to be true. If they are found to be untrue and, the underwriter has not waived the breach, he may avoid liability for a loss.

This policy covers (1) stock usual to the conduct of the insured's business and owned by him, (2) similar stock delivered or entrusted to him belonging to others who are not dealers in such property and not otherwise engaged in the jewelry trade (primarily property of his customers), (3) similar property delivered or entrusted to him by others engaged in the jewelry trade but only to the extent of his interest therein because of money actually advanced on it or legal liability for loss or damage to it. It covers the property "while the same is in or upon any place or premises whatsoever" in the continental United States, including Alaska, also the Hawaiian Islands and Canada. It covers the property while being carried or in transit by land or sea between any ports or places within the stated limits and while

being carried or in transit between them and ports or places in Europe, excluding certain countries. The goods are insured when entrusted to others as well as when on the insured's own premises.

The policy covers against loss or damage "arising from any cause whatsoever except as hereinafter mentioned," but the list of exclusions is rather long, comprising loss due to dishonesty of the assured or his employees (this is a risk to be covered by a surety bond[1]), damage due to working on the goods, loss or damage due to war, strikes, or riots, storms while on land, breakage (with some exceptions), or unexplained shortages. The insurer is not liable for loss or damage while the goods are being worn, or on public exhibition, or in an unattended automobile, or under some other like conditions of unnecessary exposure to extra risk. Notwithstanding these limitations, the coverage granted is unusually broad, as is necessary to the jewelry trade.

One of the warranties requires the insured to keep a detailed and itemized inventory of all property, including salesmen's stocks, so that the exact amount of loss can be accurately determined. The nature of the goods covered requires such records and a warranty by the insured that they will be kept. There is also a warranty that watchman service and other protective devices referred to in the proposal will be maintained so far as they are within the control of the assured. The need of this warranty is due to the high risk of burglary and theft to which such goods of high value and small bulk are exposed.

Personal Floaters.—The personal floater policies include a considerable list of forms of which the following are typical: *jewelry-fur floater*, covering against all risks in all situations with some specified exceptions the jewelry and furs of the insured and members of his family; *fur floater*, similar to the foregoing except that it covers furs only; *fine-arts policy*, covering *objets d'art* of all kinds against all risks and not limited to specific locations; *personal-effects floater*, covering similarly personal effects, "such as are usually carried by tourists and travelers," of the assured and the members of his family permanently residing with him; *personal-property floater*, covering "personal property (not pertaining to the assured's business, profession, or occupation) belonging to

[1] See Chap. XIV.

and used or worn by the assured" or members of his family of the same domicile.[1]

The last-named policy covers not merely the limited kinds of property mentioned in the other cases but extends to such things as household goods. It is an all-risk cover but specifies certain property that it is covered *only* while "permanently located in summer, winter, or country home." This latter coverage is distinctly not what is usually thought of as in the field of marine or transportation insurance, for if the goods are "permanently located" there is obviously no risk of loss or damage due to transportation. One of the risks to which the goods are exposed is, of course, that of loss or destruction by fire. Hence, as to such goods, the policy is in part a policy of fire insurance. This duplication raises a legal question in those states where the statute requires the use of a standard form of fire-insurance policy, unless the statutory definition of marine insurance in that state is broad enough to include such risks and unless marine-insurance contracts are exempted from the provisions of the standard fire-insurance-policy law. Furthermore, since the policy does not specifically separate the premium for the coverage of the fire risk on the "permanently located" property, it is not possible to determine whether the rate charged for that risk does not violate the provisions of state rating laws where they exist. This situation has caused friction and controversy between the marine companies and the fire-insurance companies. Indeed, at times the marine department of a composite fire- and marine-insurance company[2] has been found to be in competition with the fire department. Moreover, since the property is also exposed to the risk covered by a burglary-and-theft policy,[3] and since the casualty companies[4] writing this type of insurance are not permitted to cover several of the other risks included under this floater, the casualty companies have been involved in the controversy. The policy has a wide public appeal, since otherwise the property owner must procure several policies covering different types of risks on his personal property and may still not be

[1] The complete list is much longer.

[2] See p. 140.

[3] See Chap. VIII.

[4] See p. 140.

sure he is covered against all hazards. Competition has led the fire-insurance companies in some localities to offer a comprehensive endorsement[1] and to agitate for reform in the insurance laws in order to provide for a broader and simpler classification of kinds of insurance and a less narrow prescription of standard forms.

SUMMARY

1. There is no required legal standard marine policy, as it would be difficult if not impossible for other than an international government to enforce compliance with a statute requiring such a policy.

2. Notwithstanding the absence of statutory requirement, custom has led to the adoption of very similar forms by all insurers to get the benefit of uniform legal construction.

3. The principal types of risk assumed by marine insurers are

   a. Those of cargo shipment
      (1) By sea.
      (2) By land.
   b. Those of loss of, or damage to, the vessel.
   c. Those incidental to the construction of vessels.

4. Different forms are used for each of these though the basic risk transferred is substantially the same.

5. The marine policy is very broad in its coverage and free of restrictive conditions.

6. The courts have read into it certain implied warranties of which the most important are

   a. Seaworthiness.
   b. No deviation, including immediate sailing.

7. Clauses are added *ad libitum* to adapt the insurer's printed form to the particular risk to be covered:

   a. Extending the underwriter's liability to
      (1) A longer term.
      (2) A wider range of risk.
   b. Limiting the coverage in various ways, usually by warranties.

[1] See Chap. VI.

8. Marine policies are usually valued, and 100-per-cent insurance is presumed.

9. Under marine policies, total loss is presumed when, under English law and practice, the cost of salvage and repair would equal or exceed the value when salvaged, or in America, when the cost would equal or exceed 50 per cent of that value.

10. In America, there is no contribution between insurers unless policies are of the same date. In England, there is contribution, but the insured may press his whole claim against any one insurer who may then claim reimbursement from the others.

11. Blanket and floating or open policies are in general use for cargo risks and, when the insured is covered under either of these forms, certificates are issued covering individual shipments to permit transfer of payment.

12. Builder's-risk policies are used to cover the risks incidental to the building of vessels.

13. Coverage may be obtained against the risk of being held liable to pay damages to others.

14. Inland marine policies, generally known as floaters, are extensively used to cover against all risks various kinds of personal property.

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CHAPTER VIII

BURGLARY-, ROBBERY-, AND THEFT-INSURANCE CONTRACTS

Loss of their property by theft or robbery has from time immemorial been a hazard to which the owners of movables have been subject. Loss through piracy and other acts of sea marauders has always been covered under the marine policy, which has gone even farther and protected against barratry of master or crew. But until comparatively recently, it has not been possible to secure insurance protection against loss of property by theft from its normal location. The idea of such insurance was suggested as early as 1787 by one William Weller, who applied for a royal charter for a company. But though crimes of the kind were prevalent enough, the time was not ripe and nothing came of the scheme. There were sporadic attempts to start other insurance companies to cover such risks during the next century, but there was no considerable business written before about 1890. Even so late as 1900, the total volume of premiums was only about $500,000. This branch of insurance was regarded by the companies and their representatives as a mere side line, though a growing one. At the present time the business has by no means reached the saturation point, but the premium volume in 1944 of companies doing business in New York was approximately $40,000,000. This figure does not include theft insurance on automobiles which is more in the nature of a marine-insurance risk and not classified in the burglary group.[1]

Meaning of Terms.—Since the risks insured against by policies in this field of insurance arise out of actions that are criminal in nature, it might be expected that the risk covered would be described in terms synonymous with those of statute and common law. Such is not the case. The term "theft" is not in many

[1] For further discussion of automobile-theft insurance, see Chap. XV.

states a statutory term; the corresponding statutory term is "larceny," which has been said to cover a multitude of sins. The terms "burglary" and "robbery" are statutory terms, but their definition differs somewhat in different jurisdictions. It is desirable that a term used to describe the coverage under an insurance policy conform to the popular use and understanding of the term, and that it be not limited to particular jurisdictions. The terms have been defined in the policy contracts with this end in mind. This practice has given rise to the legal question whether a definition not following the statute can be set up by contract, and its observance required in the contract. The question was raised before the highest court of New York state, which held that it was permissible if the contract provision contravenes no principle of public policy and is not ambiguous.[1]

Standard-policy forms are not required by statute as in fire insurance, but the carriers, through associations, have voluntarily largely standardized the forms in use.

In the standard mercantile form, burglary is defined as loss of contents

> . . . occasioned by any person or persons who shall have made felonious entry into the premises by actual force and violence, when the premises are not open for business, of which force and violence there shall be visible marks made upon the premises at the place of such entry by tools, explosives, electricity or chemicals.

The definition in other forms except the residence policy is substantially the same. The term is not defined in most present-day residence policies as they cover theft of all kinds.

Robbery is defined in the standard paymaster and messenger robbery policy as follows:

> Robbery as used in this policy shall mean a felonious and forcible taking of property by violence inflicted upon a custodian or by putting him in fear of violence; or by an overt felonious act committed in the presence of a custodian of which he is actively cognizant (provided such act is not committed by an officer or employee of the Assured); or a felonious and forcible taking of property from the person or direct care and custody of a custodian, who, while having custody of property covered hereby, has been killed or rendered unconscious by injuries inflicted maliciously or sustained accidentally.

[1] *Rosenthal et al. v The American Bonding Company*, 100 N.E. 716 (1912).

The terms "theft" and "larceny" are, for all practical purposes, synonymous. They are used only in connection with residence, "world-wide," and office policies and are not specifically defined, because it is intended that the contracts in which they are used shall indemnify against every form of stealing; these terms, handed down through a long period of practice, are used primarily to emphasize this point. They are intended particularly to include cases where servants and others who have access to the property, misappropriate it to their own use.

Classes of Coverage.—There are at least fourteen[1] different classes of coverage in use, not including burglary and theft insurance as provided in certain recently adopted composite forms, which include several different kinds of risks in one policy. These are

1. *Residence insurance,* which covers loss of and damage to personal property from within residences or safe deposit, warehouse, or occupied residence (not owned, occupied, or rented by the insured) in which the property is placed for safekeeping, by (*a*) burglary, (*b*) robbery, or (*c*) larceny or theft.

2. *Personal-holdup insurance,* which covers loss of personal property by robbery.

3. *World-wide,* which covers loss or damage to specifically named articles of jewelry and furs anywhere in the world by (*a*) burglary, (*b*) robbery, or (*c*) theft or larceny.

4. *Bank-burglary insurance,* which covers loss of and damage to money and securities in safes or vaults by burglary.

5. *Bank-robbery insurance,* which covers loss of and damage to money and securities within the premises of the bank by robbery.

6. *Safe-deposit-box insurance,* which covers loss of and damage to securities, silverware, and jewelry in safe-deposit boxes by (*a*) burglary or (*b*) robbery. This policy is issued in two forms, one for the bank and one for the deposit-box lessee.[2]

[1] In discussing a developing type of insurance it is not possible to say definitely the number of forms in use. As the demand arises for coverage of a risk or a combination of risks not covered by existing forms, new forms are put on the market to meet it.

[2] Bank failures developed the need for safe-deposit-box insurance covering money. This coverage is available at additional premium. The bank form is also issued at a reduced premium covering only the bank's legal liability for such losses. In general, banks are not liable for losses from safe-deposit boxes unless chargeable to their negligence.

7. *Securities-insurance policy,* which covers *all loss* (except that due to infidelity of the assured's officers or employees) of securities from within a leased safe-deposit box or while temporarily outside the safe-deposit box but within the depository. For an additional premium the policy may be extended to cover within the insured's premises instead of within the depository.

8. *Mercantile-open-stock insurance,* which covers loss of and damage to stocks of merchandise, furniture, fittings, and equipment from within mercantile and manufacturing establishments by burglary when the premises are not open for business.

9. *Mercantile safe insurance,* which covers loss of and damage to merchandise, money, and securities in safes within mercantile and manufacturing establishments by burglary, and damage to premises caused by the burglary.

10. *Robbery insurance,* which covers loss by robbery of money, securities, and merchandise from a custodian within or without the insured's premises and damage to furniture, fixtures, and other property in the premises.

11. *Paymaster robbery insurance,* which covers loss by robbery of (*a*) pay-roll moneys or checks from a custodian inside or outside the insured's premises (including loss occasioned from employees on payday, provided the loss was coincidental to robbery of the custodian) and (*b*) moneys or securities, not intended for pay roll, in the custody of a custodian outside the insured's premises.[1]

12. *Storekeepers' burglary and robbery insurance,*[2] which covers loss not exceeding $250 each by the following:

a. Robbery from a custodian within assured's premises of money, securities, and merchandise; also loss or damage of merchandise from show windows broken from the outside while the premises are open for business.

b. Robbery from a custodian outside assured's premises of money, securities, and merchandise.

[1] Coverage under item (*b*) is usually limited not to exceed 10 per cent of the total coverage of the policy.

[2] This policy is designed for the small merchant, manufacturer, or garage or service-station operator who does not require the larger amounts set as a minimum for the separate types of policy. It is sold only in the fixed limits specified, and increase in the limit for any one hazard is not permitted.

c. Kidnapping, which is defined as compelling under threat of violence the return of a custodian to provide admittance to the assured's premises for the purpose of stealing.
d. Safe burglary of money, securities, and merchandise.
e. Burglary of a night depository or custodian's residence.
f. Burglary from within assured's premises of merchandise.
g. Damage by burglary or robbery to premises, merchandise, money, and securities.

13. *Office burglary and robbery policy,* which covers loss not exceeding $250 by each of the following:

a. Robbery within insured's premises of money, securities, and merchandise.
b. Robbery outside insured's premises of money, securities, and merchandise.
c. Kidnapping, which is defined as compelling under threat of violence the return of a custodian to provide admittance to the assured's premises for the purpose of stealing.
d. Safe burglary of money, securities, and merchandise.
e. Burglary from within assured's premises of merchandise.
f. Damage by burglary or robbery to premises, merchandise, money, and securities.

14. *Church burglary, robbery, theft, and larceny,* which covers loss or damage by burglary, robbery, theft, and larceny of property, including money and securities, common to houses of worship, from within (*a*) the church building, (*b*) any rectory, (*c*) any other building owned or leased by the insured for conducting religious or educational activities, and (*d*) outside the building mentioned when the property is in the personal care and custody of a custodian.

The same insured may desire coverage against the risks separately covered in two or more of the foregoing classes. It is now common to issue single-document policies that permit the inclusion of two or more of these classes. The classes covered are indicated in the declarations on the basis of which the policy is issued, and there is provision for entering opposite the statement for each class the amount of insurance and the premium. If special clauses are necessary in connection with any class, they are recited in the policy as relating to that class. There is usually a general statement that there is no insurance of any class unless an amount and premium are shown and that the amount shown is the policy limit relative to that class.

Thus, the usual residence-burglary policy may include for a separate premium theft away from the insured premises by robbery of the insured or his servants or theft from a public conveyance or a hotel, club house, or residence in which the insured is temporarily staying.[1] This coverage is limited in amount on certain items and extends only to the American continent and its adjacent islands, roughly the Western Hemisphere.

So also, classes 10 and 11 above may be covered under the same policy.

Parties.—The parties to the contracts are the company and the named insured. No special discussion is necessary under this head.

Consideration.—The consideration for the contract consists of the premium, and also of a schedule of statements or *declarations* descriptive of the risk, which is embodied in or attached to the policy and the contents of which may be made warranties under the terms of the policy. In view of the tendency of the courts to relax the sternness of the doctrine of warranties, there is considerable doubt whether, in a test case, this schedule would be rigidly construed against the insured. Rather, it seems likely that the statements would be taken as representations.

Risk Transferred.—The definition of the risk transferred to the company is accomplished partly by the terms of the basic printed policy and partly by the schedule of declarations following or preceding the body of the policy and referred to as part of the consideration for it. The policy refers to the declarations as declared by the insured to be true. Declarations are always used to describe the property covered and its location. The hazard covered by the insurer under each of the several forms has been noted above.

Under burglary policies, indemnity is also provided for damage caused to the premises in effecting or attempting to effect, entry.

Limitations and Exceptions.—The risk assumed is defined by specifying exceptions and limitations, as well as by affirmative statement. The exceptions specified are similar to those appear-

[1] If there is at least $1,000 coverage on premises (exclusive of coverage on specific items) except in Bronx, Kings, New York, and Queens counties of New York state, $1,000 of outside theft coverage is provided without extra premium.

ing in the fire-insurance contract. In a typical burglary form there are from five to ten such limitations on the liability of the company. Each can be justified on one of three grounds:

1. The coverage is offered by another form of insurance, *e.g.*, damage to plate glass. If not excluded from the burglary policy, both policies would cover, and the adjustment of losses would be complicated.

2. The condition named, as suspending or nullifying the insurance, greatly increases the hazard beyond that contemplated when the policy was negotiated, *e.g.*, damaging of the premises by explosion.

3. The condition named, as excluding property from coverage, is indicative of probable moral hazard, *e.g.*, the existence of a chattel mortgage.

The policy is voided as is the fire policy by an attempted fraud on the company and is likewise voided (and not, as in the fire contract, merely suspended), if the hazard is increased by any means within the knowledge and control of the insured, and without the consent of the company.

There is excluded from the coverage of the policy any property specifically insured by another insurer, and it is further provided that, in event of more than one policy covering the same risk, the carriers are responsible for losses pro rata.

Procedure in Event of Loss.—As prompt apprehension of the thief often results in recovery of much of the stolen property, it is the first duty of the insured under the policy in event of loss to give telegraphic notice to the company at the place where the policy was issued, and at its home office, and to notify the authorities. In other respects the procedure is substantially the same as in the case of a fire loss. The insured must furnish every reasonable assistance to facilitate the investigation and adjustment of the loss. He must file sworn proof of loss with inventories of stolen and damaged, as well as of undamaged, goods. He must submit evidence of the burglary or theft, and of any damage to the premises caused by burglary.

The similarity of the claim procedure to that in fire insurance is natural, since the burden of establishing a claim is always on the claimant, and when the burglary or theft has occurred the

condition is much the same as after a fire. Usually the loss is not total, and it is necessary to establish its extent. There is, however, not the occasion, as in fire insurance, to call in appraisers, for there will be little partial damage to specific property and hence little for appraisers to do. The policy does not provide for that method of settling disagreements as to the value of stolen property.[1]

It is possible that the event insured against may occur several times during the life of the policy and, as the coverage is limited in amount and term, any payment reduces the insurance by that amount during the remaining term of the policy. If it is desired to reinstate the insurance for its full amount, an endorsement to this effect must usually be procured at an appropriate additional premium. Some forms make the reinstatement at additional premium automatic.

Insurer's Options in Payment.—There is a provision in the policy giving the insurer the right to repair or replace damaged or stolen property with other of like kind and quality. But, owing to the nature of the risk, the privilege goes a bit farther. What fire takes is irrecoverably lost. Stolen property may be recovered by the owner or insurer, directly or through the police. The policy, therefore, provides that either party, on recovering the property, must promptly notify the other; if the insured had been indemnified or the article had been replaced, the recovered article becomes the property of the insurer, but the insured is entitled to receive or retain it on refunding the indemnity paid or reimbursing the company for its cost of replacement. In view of the possibility of loss reduction in this way, a provision is inserted giving the insurer the right to institute, and have sole charge (so far as the insured is concerned) of, criminal proceedings. The insured is not required to give pecuniary assistance in such prosecution, but to assist otherwise to the best of his ability. This imposes no undue hardship on the insured and is a valuable assistance to the insurer, especially in the case of an "inside job" under a larceny policy.

The insurer is entitled to subrogation of any right of recovery the insured may have against other parties. Subrogation exists

[1] Some forms provide for the appointment of arbitrators to determine the value of securities for which there is no quoted market value.

independent of the policy contract, but an express provision serves as a notice to the insured.

Miscellaneous Provisions.—The insurer has the right to inspect the insured's premises at all reasonable times. Under the mercantile-open-stock form it may also suspend the insurance by service of written notice. On demand, the insured may receive a refund of the premium for the term of the suspension, pro rata.

Both the insurer and the insured have the right of cancellation, the provision for which is substantially the same as in the fire-insurance policy, though the effective date of cancellation is left to be specified in the notice.

Losses are payable on receipt of proper proof. The policy prohibits the bringing of suit under it until 90[1] days after the insured has fully complied with all the requirements of the policy, or more than two years after[2] the date of the event causing loss.

Special Provisions for Various Types of Coverage.—Only movables are subject to the risk of theft, and the risk is greater as the facility of removal and disposal increases. Jewelry and furs are peculiarly subject to loss by burglary or theft, while pianos and furniture are scarcely subject to such loss at all. The companies have classified property into five groups from this point of view as follows:

1. Watches, necklaces, gems, precious and semiprecious stones, jewelry, articles of gold, platinum, and sterling silver, furs and articles made entirely or principally of fur.
2. Money, securities, stamp and coin collections,[3] wearing apparel, laces, rugs, tapestries, pictures, paintings, plated ware, and all other household goods, and personal property common in residences generally, including professional instruments, and electric light, plumbing, gas and water fixtures.
3. Wines, liquors, and alcoholic beverages legally acquired by the assured.
4. Horses, cattle, vehicles, automobiles and motorcycles, and fittings and appurtenances thereof, harness, saddles, tools, and like property, excluding robes, blankets, and wearing apparel while contained in the private stable or garage adjacent to or in the building in which the premises of the assured are located.
5. Articles separately and specifically insured and, therefore, excluded from the preceding groups, with the exception of silverware which may be

[1] Forty days in bank and safe-deposit policies.

[2] One year in world-wide policy.

[3] Up to $50.

insured as a collection. These articles must be enumerated and described in detail; for example:

One platinum ring containing solitaire diamond, 1¼ carats, name of owner, date of purchase, name of merchant or previous owner, purchase price;

One Hudson seal fur coat with beaver collar, length 40 inches, name of owner, date of purchase, name of merchant or previous owner, purchase price.

The first two and the last classifications of property are of the greatest importance in connection with the forms of coverage to be described, because the essential differences between the forms arise out of the methods employed in insuring these particular types of property.[1]

Residence Policies.—Three coverage arrangements at rates adjusted to correspond are offered:

1. Combined coverage of all property in classes 1 and 2. Formerly this form was subject to 100-per-cent coinsurance, because otherwise there would be temptation to insure only a limited value to cover the loss of the most valuable goods. The coinsurance provision is not now insisted upon, but the rate is much higher than for the other forms.

2. Similar coverage without the coinsurance requirement, but providing that the total amount on the first class of property shall not exceed 50 per cent of the total insurance.

3. Divided coverage under which the amount of total insurance on each class is set down in the policy. This form is issued either without coinsurance or with an 80-per-cent coinsurance clause.

Under all three forms specific property may be separately valued and insured.

Property of the fourth class enumerated above is not ordinarily covered but may be covered by a suitable endorsement.

Mercantile Policies.—In the main, the provisions of mercantile policies are similar to those of residence policies, but some special provisions are necessary. There is not the separation of property into types with special insurance limits on each type. Aside from a limit of $50 for loss of or damage to any one article of jewelry, the policy covers, broadly, merchandise, furniture, fixtures, and equipment. The insuring company does not assume

[1] Michelbacher, G. F., and L. H. Carr, "Burglary, Theft and Robbery Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XI, pp. 51–52. Since the repeal of the 18th amendment the third class does not present the high hazard it did when this paper was written.

liability if the insured, any associate in interest, servant, or employee is implicated as principal or accessory. Protection against such a hazard should be obtained by suitably bonding the employees. The company does not assume liability unless books and accounts are regularly kept so that the exact amount of a loss may be ascertained. Nor does it assume liability for loss when the premises are open for business. This policy always contains an average clause. The percentage required varies with the type of goods covered.

The premises covered are "limited to that portion of the interior of the building designated in the schedule, occupied solely by the assured in conducting his business." The policy specifically excludes showcases or show windows not opening directly into the interior of the premises, as well as public entrances, halls, and stairways. And the company does not assume liability for theft of furs and fur goods from a show window after the glass has been broken from the outside, unless it is specifically provided for in the schedule. A specific additional premium is charged when this is included. This is due to the high value of such goods, and the lack of protection at night when they are left on display. Several very large losses have been suffered by New York merchants by this type of burglary. The increasing use of swift automobiles makes this hazard a constantly increasing one.

Banks.—Owing to the peculiar hazard of burglary and robbery to which banks are subject, the American Bankers' Association has drawn up and copyrighted a standard-form bank-burglary and-robbery policy.

SUMMARY

1. Burglary-, robbery-, and theft-policy forms are not standardized by law but by agreement between the carriers, and in one case by the American Bankers' Association.

2. The terms describing the criminal act insured against are given popular rather than technical legal meaning.

3. A wide variety of forms of contract is offered to meet the need of the insuring public, but the difference is largely in the definition of the risk. Other essential features are substantially the same.

4. The contracts conform to the general proposition that the insurance contract is one of indemnity based on loss to specific property of the insured at a definite place.

5. Automobile-theft insurance is in the nature of marine insurance.

Reference

Kulp, C. A., "Casualty Insurance," rev. ed., Chap. 11.

CHAPTER IX

OTHER PROPERTY-INSURANCE CONTRACTS

It is impossible, in a general survey, to present in full analysis all forms of insurance policies in use to cover the hazards to which property is exposed. In this chapter the more common forms of property insurance, in addition to those discussed in the preceding chapters, will be briefly reviewed. The reader should not assume that the list is complete, for as new needs for insurance develop, the business expands to meet them and, just as several of the lines described in this chapter are of comparatively recent origin, so it is to be expected that in the years to come additional lines will be developed.

Causes of property loss, other than those already discussed, against which insurance is available include

1. Water leakage from sprinkler systems or other piping.
2. Breakage of plate glass.
3. Explosion of steam boilers or flywheels.
4. Burning out of electric machinery.
5. Riot and civil commotion.
6. Windstorm or tornado.
7. Earthquake.
8. Hail.
9. Frost.
10. Rain.
11. Death of livestock.
12. Defective title to real property.
13. Failure of debtors.

Classification According to Carrier Groups.—Before describing these various contracts it is necessary to anticipate briefly what will be more fully discussed later, and to note that the laws of most of the various states governing the formation of insurance carriers do not permit an individual carrier to do any and all kinds of insurance business, but permit one class of carriers to write certain lines, while other lines are reserved to another group of carriers.

In general, there are four principal groups of insurance carriers:

1. Fire-insurance carriers.
2. Marine-insurance carriers.
3. Life-insurance carriers.
4. Miscellaneous or "casualty" carriers.

There are also special types of carriers such as title-insurance companies which are restricted to single lines of insurance.

This classification is a resultant of a traditional separation in earlier and simpler times, which has become embedded in our laws and is not generally found abroad. It has necessarily had a profound effect on the forms of contract under which the various hazards are covered, and in other ways.

In most states, fire-insurance carriers, if possessed of sufficient capital, may also do a marine-insurance business; and a life-insurance carrier may, in a separate department, transact certain other lines, such as accident and health insurance, which are personal in their nature, but they may not write fire insurance and kindred lines.

The fourth group began with personal-accident insurance and a few kindred lines but has gradually extended to cover a wide field, including insurance of many property hazards as well as personal hazards.

In general, it may be said that the following kinds of property insurance are furnished by fire-insurance carriers, though not all such carriers write all of them:

Riot-and-civil-commotion insurance.
Windstorm and tornado insurance.
Earthquake insurance.
Hail insurance.
Water-damage insurance.
Rain insurance.

Also, in general, it may be said that the following kinds are transacted by casualty companies:

Burglary and robbery insurance.
Plate-glass insurance.
Boiler and flywheel insurance.
Electric-machinery insurance.
Credit insurance.

Sometimes all kinds of insurance in either of the above groups are written by one carrier, but there are many carriers writing only one or two of them as exclusive lines. Some lines are written by both types of carriers.

Livestock insurance and title insurance are usually exclusive lines with the carriers that write them.

General Forms of Policy Contracts.—Many of the additional lines written by the fire companies are written by endorsement added to a standard fire-insurance policy. Examples of such lines are earthquake insurance and business-interruption insurance, including as such, profits, rental income, and use-and-occupancy insurance.

For other lines separate policy forms are prepared. These forms, however, are modeled as closely as may be on the standard fire policy in order to obtain the benefit of the judicial construction which has been given that form from time to time.

Extended Coverage.—As was noted earlier,[1] it is now customary in many jurisdictions for fire-insurance carriers to provide under their fire-insurance policies "extended coverage" for which an appropriate additional premium is charged. The perils so covered are those of *windstorm, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles, and smoke.* The policy is extended to cover these hazards by substitution of terms. It is provided in the endorsement that, in applying the policy provisions and those of the endorsement, whenever the word "fire" appears there shall be substituted the peril involved or the loss caused thereby as the case requires. There are a few special clauses in the endorsement relative to some of these perils which appear necessary to define the risk assumed.[2] Smoke damage from a hostile fire has long been recognized as a fire loss, but from time to time the carriers have been presented with claims for smoke damage due to faulty operation of household heating plants. These claims have occasionally been allowed by the courts, but in general the loss is held due to a friendly fire. Nonetheless the insured has sustained a troublesome loss, inclusion of which in the extended coverage is mutually satisfactory. The other perils are those to which most insureds are

[1] P. 86, with citation to Appendix II, Dwelling and Contents Form.

[2] See endorsement as a part of the form in Appendix II.

exposed though to a low degree, such that at the minimum premiums required for separate policies they do not often take insurance against any of them. The fire policy with extended coverage endorsement is not quite an "all-risk" policy. It does not include theft coverage. That is probably the only major property risk of the household not covered by the endorsement.

Earthquake Insurance.—In the earthquake form,[1] used to transform a fire policy into an earthquake policy, the most important change made is the substitution of the word "earthquake" for "fire" whenever it occurs, and the elimination of those provisions in the standard fire policy which obviously cannot apply to earthquake insurance. No attempt is made to define an earthquake other than by the use of the term "earthquake" to define the phenomenon which causes the loss or damage, but an attempt is made more sharply to define the risk by providing that "if more than one earthquake shock shall occur within any period of seventy-two hours during the term of this policy, such earthquake shocks shall be deemed to be a single earthquake within the meaning hereof." Since earthquake damage is usually partial, the endorsement provides for a certain percentage of coinsurance.[2] Trivial losses are excluded. Including such losses would increase the rate to a prohibitive figure.

Business-interruption Insurance.—The problem in the case of business-interruption insurance is of a different nature. The hazard here is of a loss by fire, earthquake, or other casualty, but a consequential loss which is excepted under the standard-policy forms for covering direct loss of property. The policy itself may stand without material modification in defining the basic risk transferred so far as the *cause* of the loss is concerned, as well as in prescribing the loss-settlement procedure and the other rights and obligations of both parties. The kind of consequential loss which results from a fire, however, is dependent both on the type of premises and the manner of use (*e.g.*, continuous or seasonal), and very careful phrasing is necessary to

[1] See Appendix XVII.

[2] The demand for earthquake insurance is almost exclusively on the Pacific coast. There the rule is that the percentage of coinsurance shall be not less than 40 per cent. A reduction in rate is granted if a higher percentage is provided.

define clearly from this standpoint the risk assumed. Depending on the circumstances, the policy may cover the rental lost by the inability of tenants to use the premises (rent insurance); or the anticipated profits lost during the time when unable to use or occupy the premises for manufacturing or merchandising and the necessarily continuing expenses (use-and-occupancy insurance).[1] Since both profits and expenses are variable quantities and more or less under the control of the insured, it is necessary to define them with reference both to past experience and to probable future experience in order to do justice and avoid moral hazard. In the case of a seasonal industry, it is necessary to provide an adjustment of the amount of insurance to the probable degree of loss corresponding to the part of the year when the fire occurs. This form of insurance is still in its development stages, and modification of the forms and practices are to be expected, but it is not likely that basic principles will be materially changed.

Riot-and- civil-commotion Insurance.[2]—As its name implies, riot-and-civil-commotion insurance covers against loss or damage due to strikes, riots, and like violence. The coverage is of an insured on certain property for a fixed time and up to a fixed maximum limit from the causes stated:

> (1) Riot; (2) insurrection; (3) civil commotion including strike; (4) explosion directly caused by any of the foregoing; (5) explosion occurring from causes other than above described (excluding fire resulting from such explosion) whether originating on the premises of the assured or elsewhere.

But explosions originating within the boilers, flywheels, or engines of the assured are excluded.

As such insurance will naturally be desired only in times of actual or expected stress and may be desired for a short time only, it is necessary to safeguard against abuse on both sides. The policy is void if the premium is not received within 30 days from its beginning date. The policy cannot be canceled within

[1] See pp. 95–96 and Appendix XI.

[2] Since this risk is included in the extended-coverage endorsement on fire policies, it seems probable that in most cases it will be so covered. However, separate policies are still offered.

90 days by either party, but after that it may be canceled on substantially the same terms as the fire policy.

The limitation of recovery to the actual cash value of the property destroyed, and the exclusion of certain property, follow, in general, the fire policy, as does the loss-settlement procedure. By its terms the policy does not concern loss covered under fire or any other form of insurance contract. This clause is intended to prevent double recovery.

Windstorm Insurance.[1]—Tornado insurance covers direct loss or damage to specified property by "windstorms, cyclones, and tornadoes." As may be understood from this language, the intent is to cover damage by wind only. But high wind is often accompanied by rain, hail, snow, or other meteorological disturbance, and it is necessary, in a precise definition of the risk assumed, to indicate plainly that the company does not cover these risks. The following clauses are taken from the policy in use by one of the leading companies:

This Company shall not be liable for any loss or damage caused by hail, whether driven by wind or not, snowstorms, frost or cold weather, nor for the blowing down of metal smoke-stacks (unless specifically insured), awnings, signs, temporary or board roof additions, nor for loss or damage to buildings (or their contents) in process of construction or reconstruction, unless same are entirely enclosed and under roof, with all outside doors and windows permanently in place; nor for loss or damage occasioned directly or indirectly by or through any fire, explosion, tidal wave, lightning, high water, overflow, cloudburst; nor by theft, nor by reason of any ordinance or law regulating the construction or repair of buildings, or for consequential loss of any kind.

This Company shall not be liable for any loss or damage caused by water or rain, whether driven by wind or not, unless the building insured or containing the property insured shall first sustain an actual damage to the roof or walls of same by the direct force of the wind, and shall then be liable only for such damage to the interior of the building or the insured property therein as may be caused by water or rain entering the building through openings in the roof or walls made by the direct action of the wind.

[1] Since this risk is in the extended-coverage endowment on fire policies, it seems probable that in most cases it will be so covered. However, separate policies are still offered.

. . . It is expressly stipulated that only such proportion of the insurance under this policy on any building covers on plate, stained, leaded or cathedral glass therein, as the value of such glass shall bear to the value of said building; and to such extent only shall this Company contribute with other insurance in payment of any loss thereon; and plate glass, accident or casualty insurance shall be deemed other insurance and treated as contributing.

The reason for the restrictions with regard to damage to glass is its high susceptibility to loss by wind breakage. Without such a clause the rates for this form of insurance would be considerably higher, because of the increased proportion of losses that would be sustained in relation to the amount of insurance to be taken. Aside from breakage of plate glass, separately coverable under plate-glass insurance, no individual risk is likely to sustain a severe glass loss. Though the policy is briefer and simpler, it follows in other respects the fire-insurance contract.

Hail Insurance.—Hail insurance is written only on agricultural crops since they are about the only property susceptible to material damage by hail. But the very precariousness of such crops in general, and the fact that the insurer cannot know precisely the condition immediately preceding the storm, make the possibility of moral hazard high, and particular precautions are taken to guard against it. Among these are

1. The issuance of a policy only on a signed application which contains practically the entire contract and which must be signed in duplicate by both applicant and agent of the company. One copy is attached to a form that contains the agreement of the company to insure according to the specifications in the endorsement, and carries the facsimile signatures of the officers of the company. This is the policy given the insured.

2. A provision in the application policy that the insurance begins 24 hours from the date of signing by the applicant and the agent.

3. A provision in the application making the insurance cover provisionally until 24 hours after receipt of the application by the company at its policy-writing office, within which time the company must issue the policy or decline the business. If the company declines, it must immediately notify the applicant by

telegram or mail and the insurance ceases on the delivery of the notice.

The policy provides settlement of partial losses on a 100-per-cent coinsurance basis. It does not have a fixed term, as do most property-insurance policies, but has an expiration limit, *e.g.*, Sept. 15 or Nov. 1, when crops will ordinarily have been harvested and the hail season over. It also ceases on the harvesting of the crop and is diminished automatically as parts of the crop are harvested. There is no liability assumed for damage to blossoms of trees or vines or for damage to corn, grain, or similar annuals unless the plants have made a certain minimum growth. Every effort is made to read out any other type of loss than strictly hail damage. If it is possible to replant the acreage and make a crop, the liability is limited to the cost of replanting. Loss of less than 5 per cent is not covered by the policy. The insured must notify the company by registered mail within 48 hours of hail damage and file his proof within 120 days. No abandonment to the company of any crop is permitted.

The company retains the right to cancel at any time by refund of the entire premium paid.

Many of these terms seem severe but are believed necessary to avoid moral hazard.

Frost Insurance, General Crop Insurance.—There has been demand for frost insurance by the growers of both citrus and deciduous fruits, and efforts have been made to meet it though this cover is not widely written. One difficulty has been that of determining the amount of actual loss. If the fruit is partly matured or well set when the damage occurs, it is possible to estimate the physical damage at the time. But the financial loss depends on the value of the crop. The taking out of the market of part of the crop tends to enchance the value of what is left. Some policy forms provide for partial settlement within a fixed time after the damage with the final payment deferred until the close of the season and the marketing of the saleable crop, if any.

General crop cover including losses from drought, blight, insect pest, and other causes is still so in the experimental stage that no adequate discussion can be given in the space available. The greatest difficulties have been to secure an incentive to full care of the crop to prevent and minimize the loss, and proper

arrangement for settlement so that the policy may not, in times of falling prices, become really a price rather than crop-damage insurance. As there is a real need for such coverage, it may be expected that within a reasonable time a way will be found to provide it.[1]

Rain Insurance.—Rain may crack cherries, spoil hay, and otherwise do damage to crops, but more often it is beneficial. Rarely, if ever, does rain cause direct property loss. But the consequential damages of an unexpected shower are often large. For example, the calling off of a championship baseball game with rain checks for a subsequent date involves heavy additional expense. Rain insurance was devised to meet such situations. It is, like the business-interruption insurances, a consequential damage insurance, but unlike them, in that the indemnity is not dependent upon time required to repair or restore property damaged or destroyed.

A number of different forms of rain-insurance policies are written according to the type of venture covered, *e.g.*, public exhibitions covering several days and a number of features such as a county fair; a department-store special sale for which extensive preparation has been made by advertising; and public entertainments, such as baseball games. The major difference in these forms is in the basis set up for determining the amount of loss.

The loss under the policy becomes payable if a given amount (usually 0.1 or 0.2 inch) of rain falls between the hours, specified in the policy, of a day or days also named in the policy. The insured is required to arrange for an official reading with a rain gauge at a named point. The insurance covers loss of expected income or expenses incurred or both.

Local agents are not, as in certain other lines, furnished policy forms to be issued and reported on a daily report to the company, but must submit an application, on a form provided, for approval at least a week before the event. Cash for the premium must accompany the application. The policy is by its terms not cancelable by either party. If these requirements of cash in advance and no cancellation were not made, the companies might readily be victimized by applicants who prolonged negotiations

[1] See pp. 300 for discussion of Federal Crop Insurance.

until almost the time of the event, closing them if the weather appeared threatening but breaking them off if the prospect of rain seemed remote. Retention of the right to cancel by the company in any event would arouse the suspicions of the insured as to the good faith of the company. Further, the hazard being of a natural phenomenon beyond the control of the insured and the policy being issued by a head office, there is no reason why the company should desire to have this right. Since the method of determining the amount of indemnity varies with the nature of the risk, details regarding it cannot be given here without unduly emphasizing a minor type of insurance. It will suffice to say that it is designed to measure the exact expense incurred, which must be duplicated, or the reduction in income actually brought about by the rain, or both. The other important clauses are similar to those in other lines of property insurance.

Water-damage Insurance.—Although the introduction of the automatic sprinkler reduced, wherever it was installed, the hazard of loss by fire, it carried with it a new, albeit lesser, one, that of damage by water leakage from the system. The fire companies met the demand for insurance against this hazard by using a simplified policy modeled on the fire-insurance policy. The insuring clause covers

> Against all direct loss or damage caused by the accidental discharge or leakage of water from the automatic sprinkler system, including tanks supplying it, except as hereinafter provided, in or on the buildings now erected and occupied wholly or partly by the assured (whether the accident occurs in the portion occupied by the assured or not), described and located as follows.

The exceptions to the company's liability are loss or damage when the leakage is caused by fire, lightning, earthquake, explosion, invasion of foreign enemies, civil commotions, riots, any military or usurped power, order of a civil authority, or any fraudulent acts of the insured. Damage to the system itself is also excluded. The reasons for these exclusions should be readily recognized. In many cases, *e.g.*, fire, damage due to the original cause is insurable in a policy covering more generally and, as such a policy would cover, it is easier to make the exclusion than to settle the complex questions of contribution in the case of

overlapping insurance. In other cases the insured will have other redress, *e.g.*, the damage due to the order of a civil authority.

It is now possible to insure under a similar policy covering not only sprinkler leakage but accidental leakage from any other plumbing on the premises.

Glass Insurance.—Large glass plates are expensive and are susceptible to breakage from many causes. The major loss, however, to a large mercantile establishment is the loss of trade due to the temporary boarding up of broken show windows. The merchant desires replacement with a minimum delay. The policy is intended to provide this. But sometimes the inability promptly to procure the glass or to procure the services of skilled glass setters prevents the company from making a prompt replacement, and it therefore reserves the right to settle in cash. The comprehensive glass policy now offered is based on a schedule giving the name and address of the insured and a description of the glass and lettering to be covered.

The insuring clause agrees to indemnify the assured for

I. *All Damage* to such glass, lettering, and ornamentation, caused by
   (*a*) the accidental breakage of such glass, except damage by fire in the Assured's premises or elsewhere.[1]
   (*b*) acids or chemicals accidentally or maliciously applied thereto provided such glass, lettering, or ornamentation so damaged is thereafter unfit for use for the purpose for which it was being used immediately preceding the occurrence of such damage.

II. *The Cost* (not exceeding $75) of repairing, or replacing with like material, window sashes and show case frames immediately encasing and contiguous to the insured glass, provided that such repairing or replacing is made necessary by such damage to the insured glass.

III. *The Cost* (not exceeding $75) of boarding up, or installing temporary plates in the windows in which such broken insured glass is located provided such boarding up or temporary installation is necessitated by unavoidable delay in replacing any broken glass insured hereunder.

IV. *The Cost* (not exceeding $75) of removing and replacing any fixtures or other obstruction (excluding show window displays) necessary to the replacement of any such glass insured hereunder.

[1] This is covered by his fire-insurance policy.

The policy further provides:

> The Company shall replace, without unnecessary delay, any such damaged glass, lettering or ornamentation insured hereunder, or pay for the same in money within the limits provided herein, as the Company may elect. In either case, the damaged glass shall be the property of the Company.

The other provisions are similar to those found in other property-insurance policies, but the requirement of notice of loss is that it shall be given "as soon as practicable," and the usual obligation to preserve the property from further damage is expressed in the more emphatic language "the Assured shall make all reasonable efforts to preserve the glass and to prevent further damage." The speed with which a neglected crack in plate glass may elongate and prevent salvage of any part of the plate is the reason for these provisions.

Livestock Insurance.—Livestock insurance has been practiced from very ancient times by mutual benefit associations. It is carried on at the present time both here and abroad by many small associations and to some extent by commercial carriers. Despite the extent of the dairy and meat-cattle industries it is not commercially important. The major impediment is moral hazard. Two conditions make it very hard to control. Unless an animal is branded or earmarked with an individual mark distinct from the herd mark, it is usually impossible so to identify it as to permit individual insurance. If a herd is covered, then the problem arises of keeping a proper ratio of insurance to value. The kind of care, feeding, and protection given the animals is of greatest importance in determining the chance of loss, and there is no satisfactory way of checking up before loss and little chance of proving neglect or worse after loss. Values of livestock are variable and in a very brief time highly valued breeding stock may become almost worthless, thus promoting moral hazard. A hint of this is found in the italicized language from a policy designed to cover such stock:

> Against loss arising from the death on the premises described in the application, or while temporarily elsewhere in the vicinity thereof, of any or all the animals hereby insured . . . including loss arising from the necessity of the destruction of any of said animals arising directly from

any casualty, but the company shall not be liable beyond the actual cash value of any animal at the time any loss occurs *in the condition in which said animal then may be.*

Exceptions specified in the policy are

1. Cost of removal or disposal of the remains of any animal.
2. Loss resulting from any disease or injury of any animal not requiring its destruction.
3. Depreciation in value resulting from such disease or injury.
4. Death of any animal caused by any person, with the consent of the owner, but without the consent of the company.
5. Death caused by invasion, insurrection, riot or war.
6. Death due to the insured's carelessness or neglect.
7. Death by order of civil authorities.

The policy resembles the fire policy in its provision for cancellation, appraisal, subrogation, and like conditions.

This policy is a mortality policy covering in a specific location. There is another full floater, full mortality policy covering anywhere in the United States or Canada and including the risk of transportation. That form is used to cover race horses, show horses, and similar stock.

Livestock may be covered against loss by fire or lightning under an ordinary fire policy and against the risk of transportation under an ordinary marine policy. There are also special livestock policies issued covering these risks.

Trip-transit policies provide protection against loss of animals while in the hands of transportation companies. These are issued in two forms, one covering against loss by death from any cause during transportation and the other against loss resulting only from fire, derailment, and collision.

Boiler-and-machinery Insurance.—When a steam boiler explodes from excessive pressure or when rapidly moving machinery is torn apart with explosive energy by centrifugal force, its owner may suffer loss

1. By the destruction of his own property.
2. By being held liable for destruction of the property of others.
3. By being held liable for the death or injury of persons, caused thereby.

The boiler-and-machinery policy offers protection against all those. For many years the only insurance offered was that

against boiler explosion. Later, insurance was offered under separate policies for other types of machinery breakdown. In accord with the general tendency toward unification and coverage of all similar risks of one insured under a single policy, the present-day boiler-and-machinery policy is basically comprehensive and covers all forms of machinery breakdown. This necessitates some unique provisions in the policy and extensive use of attached schedules in order to describe the risk transferred.

It insures against loss from an accident to an *object* while it is in use or connected and ready for use at the location specified in the schedules which are attached to and made a part of the policy. The objects are designated and described in the schedules. They may be boilers, unfired pressure vessels, auxiliary piping, engines, wheels, shafting, turbine units, etc. Since machinery is generally set up and interconnected, there may be doubt about just what constitutes the particular object covered. Each schedule, therefore, contains a formal definition of the object with specifications and limitations. An example of such a definition is the following taken from a boiler schedule:

> Object shall mean the complete boiler or other object designated in this Schedule, including any steel economizer used solely with the Object, any apparatus under pressure which is wholly or partly within the setting or furnace of the Object, any indirect water heater, not forming part of a water storage tank, installed outside the Object, if such heater is directly in the boiler water circulation, and the interconnecting piping and fitting of the Object: but shall not include any cast iron economizer unless specifically designated herein; or any piping leading to or from the Object except any blow-off pipe to and including the nearest valve on each such pipe.[1]

The term "accident" in the insuring clause also requires definition appropriate to the object covered. In a standard boiler policy the definition is

> A sudden and accidental tearing asunder of the Object, or any part thereof, caused by pressure of steam or water therein, or a sudden and accidental crushing inward of a cylindrical furnace or flue of the Object so caused; but "Accident" shall not mean the cracking of the Object, or any part thereof, nor the tearing asunder of any safety disk,

[1] A broader form includes such piping with an appropriate paragraph modifying the definition of the object.

rupture diaphragm or fusible plug, nor leakage at any valve, fitting, joint, or connection.[1]

For other types of object somewhat similar definitions are necessary and are given in the corresponding schedules.

The policy sets a limit per accident and defines one accident to include all resultant or concomitant accidents to one or more than one object or part of an object but does not set a further total limit of liability.[2]

The indemnity promised is, first, to pay for loss to the property of the insured directly damaged by the accident, with the option left to the insurer to repair or replace, excluding loss due to fire or the use of water or other means to extinguish the fire, or loss from accident due to fire,[3] loss from delay or interruption of business or manufacture or process, loss from lack of power, light, heat, steam, or refrigeration, and loss from any indirect result of an accident. Second, it is promised to pay for reasonable extra cost of temporary repair of the damaged property not exceeding the amount of the property loss itself and not exceeding $1,000. Third, if the sum of these two items does not reach the policy limit, it is promised to pay such amounts as the insured is obligated to pay by reason of liability for loss on property of others directly damaged by the accident and to defend the insured against claims and suits, but the amount payable under this clause is limited to the excess of the limit per accident over the amount paid under the two previous items. Fourth, the insurer promises that, to the extent of the indemnity remaining after taking care of the items referred to, it will pay the amounts for which the insured becomes liable by reason of bodily injuries sustained by any person and caused by the accident, excluding, however, liability under any workmen's compensation law. Defense of suits is promised in this connection. The insurer also promises, regardless of the limit per accident, to pay for such immediate surgical relief as shall be rendered those injured at the time of the accident. It also promises to pay the legal expense incurred by it in defending claims and suits as well as the court

[1] A broader form includes cracking and some other injuries.

[2] More than one serious accident within the period of a policy is a remote contingency.

[3] Covered under the fire-insurance policy.

costs without regard to the limit per accident set in the policy.

Another provision of the policy qualifies the promise with respect to bodily-injury liability by stating that it covers only the excess of the insured's liability over the amount of any liability insurance[1] he may have that would cover the loss. This provision and the order in which the losses are taken up give the insured the maximum of benefit from his boiler and general-liability policies.

Boiler insurance is usually carried with the expectation of the protection of regular and expert inspection of the boiler, and the carriers give that service. They do not promise it, because if a carrier is unable to make the inspections as frequently or regularly as contemplated, and in the interval between inspections a serious explosion occurred, the carrier might be subject to a heavy damage suit in addition to its policy liability on the theory that its negligence in inspection was the cause of the loss. The policy provides that the company shall be permitted to inspect at all reasonable times during the policy period.

In connection with the inspection privilege the policy provides that any representative of the company, on the discovery of a dangerous condition, may immediately suspend the insurance by written notice delivered on the spot. The insurance may be reinstated by endorsement. The company refunds the unearned premium for the period of suspension under hazardous conditions. In other respects the policy is similar to others discussed above.

In addition to the general boiler-and-machinery policy, primarily intended for manufacturing concerns, off-premises explosion insurance and residence explosion insurance are available.

Business interruption due to damage to boilers or machinery may be covered by modification of the basic policy in a manner similar to the modification of the basic fire policy to make it cover business-interruption losses.

Title Insurance.—Title insurance is an outgrowth of the business of record searching to determine the title to real estate. The abstract or report of title prepared by a lawyer or other professional searcher of titles contains no guarantee that no

[1] See Chap. XII.

defects exist in the title. If negligence of the searcher employed can be proved, a damage suit may be instituted, but recovery is dependent on his financial responsibility. The title-insurance policy agrees to indemnify the insured up to the limit named in the policy against loss due to defects in the title to the real estate covered, subject to the exceptions named in the policy. These exceptions are limitations of record on the title by reason of covenants, building restriction, easements, etc. This policy does not cover against something to occur in the future, but against loss that may be sustained in the future owing to defects existing, but undiscovered, at the time it is issued. Consequently the policy is not issued for any fixed term. It is not, like the ordinary insurance contract, a contract of indemnity intended to spread safely and equitably uncertain future losses over a group exposed to them. Rather, the service performed by the company is an attempt to prevent loss from defective title by careful search, the quality of that service being supported by a financial guarantee. In a sense, the boiler company performs a similar service, but it also performs a true insurance function albeit the insurance is of a remote contingency of catastrophic proportions. In a later chapter it will be shown that another business usually classified in the group of insurance enterprises is in this respect similar to title insurance, *viz.*, surety bonding.[1]

Credit Insurance.—Failure of debtors is a cause of loss to businessmen, which, in some respects, is due to their own business policy in extending credit and to some extent almost accidental. Credit insurance offers to manufacturers and wholesale merchants (it has not yet been extended to other classes) coverage against credit losses in excess of normal. Since the extent of such excess losses depends on the amount of normal loss, on the credit practice of the insured, and on collection methods, the policy must clearly define what is agreed to in these respects. If the company is to be able to minimize loss, it must have the opportunity to attempt collection of accounts likely to result in claims.

To provide for all these things the terms of the policy are very complex, and a satisfactory analysis cannot be presented

[1] See Chap. XIV.

without giving more space than the present importance of the business seems to justify in a book of this kind. Readers desiring a more complete discussion are referred to the special writings on this subject.[1]

Aviation Risks.—The development of aviation has brought with it many new risks. Among the risks to property are those of destruction or damage to the plane itself, or its contents, as well as of damage to property on the ground caused by fall of planes, or of contents of planes. Insurance may be obtained against these risks. The field is so new that forms and practices are not yet so stabilized as to justify detailed description of present forms in a book of general character. This is particularly true because of the number of such forms.

In general, contents are covered substantially as are other inland transportation risks as a branch of marine insurance. Fire insurance is written on two forms: one covering only fire in the air, the other fire under all circumstances. Crash insurance is of necessity written with a large deductible average. A special form is written in some parts of the country covering tornado risks.

Damage to property on the ground should be recoverable from the owner or operator of the plane and he may carry insurance against his liability. But if he is not financially responsible and has no such insurance, then the owner of the destroyed property would have to bear his own loss unless he had insured against it. Such insurance is obtainable. Their distinctive feature is, of course, the description of the risk transferred.

From time to time demand comes for new forms of insurance such as that against explosion or increased cost of construction, which are excluded from the usual forms of property insurance. The important characteristic of such forms as have been issued and the fundamental requirement in such as may be developed in the future is a clear definition of the risk to be transferred. It is always necessary to observe the possibility of moral hazard and fraudulent claims and insert clauses reasonably safeguarding against them. Such clauses are, like policemen, a cause of uneasiness to some honest persons who, like the small boy, fail

[1] See, for example, John E. Gregory, "Credit Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. VIII, pp. 266–272.

to understand that they are for their protection against excess cost through dishonest claims, but on the whole a defense for the public interest.

SUMMARY

In this chapter there have been outlined the important distinctive features of several types of property-insurance policies of lesser importance. They have been found to conform in their general terms to the forms of policies in use in other lines. A group has been noted in which, though a formal policy of insurance is issued, the principal service of the insurer is systematic effort at prevention of the potential loss. This distinction will be found of importance when methods of premium rate making are considered.

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CHAPTER X

LIFE-INSURANCE AND ANNUITY CONTRACTS

The principal risk with which life insurance deals is that of loss of future income due to the untimely death of the income producer. But what is untimely death in this connection? Some men cease to be income producers at a comparatively early age, and, because of sickness or deformity, their prolonged life involves not only no continuance of income but on the contrary continued expense. Others continue in active life as producers until they reach advanced age, sometimes of necessity to care for those dependent on them and sometimes from choice. There is no fixed age at which it can be generally said that, thereafter, there is no loss of income caused by death. Always there is greater or less expense involved in burial of the deceased and rearrangement of family affairs. If there is property left, inheritance taxes often must be paid. Hence, though it may be desirable in individual cases to transfer to an insurance carrier merely the risk of death prior to a certain age, the service of insurance will not be complete if it is not prepared to accept the risk, and combine and redistribute the loss up to whatever age the insured may live.

UNIQUE CHARACTER OF THE SUBJECT MATTER OF LIFE INSURANCE

When the foregoing observations are pondered, it is found that the risk with which life insurance is concerned is different in certain fundamental respects from those with which other kinds of insurance are concerned. The most important differences are

1. The event insured against (death of an individual) is bound to happen. If the time element is disregarded, there is no uncertainty. The risk is not that loss will occur because a person dies, but that he may die within a particular interval of time. This is the risk with which the life-insurance contract is concerned.

2. The hazard increases from year to year. It may be that this is true of certain other risks. For example, an old house presumably is a worse risk for fire than a new one, but not necessarily so if kept in proper repair; it may even be made a better risk. As its condition gets worse, its value decreases. But a human life may be increasing in value, owing to experience and consequent increase in earning power, as the chance of death is increasing, if not through actual deterioration of the individual (considering his age), then through natural tendency to ultimate death. Even in the most rigidly selected groups, the deaths among 1,000 men aged fifty are more frequent than among 1,000 youths aged twenty.

3. There is no possibility of partial loss. There may be impairment of earning power but the risk of this loss is covered in other insurance fields, *e.g.*, accident-and-health insurance and workmen's compensation.

4. It is impossible to place a natural monetary value on human life. In the case of physical property we may estimate the cost of reproduction, which gives a natural limit of possible loss. In the case of liability insurance, judgments are expressed in monetary terms. Even in the case of personal accident we may know the income earned before injury and that immediately after. It might appear that we could value the life by considering the value of its income-producing power. To do that we must know what the income will be all through the remainder of life even to extreme old age. Clearly this cannot be so accurately approximated that it could serve as a basis of loss adjustment. At the death of a person he may have been on the verge of a great discovery or invention that would have made a vast fortune. In an individual case, who knows?

5. The risk is little affected by the personal characteristics of the beneficiary.

6. The person insured, who usually negotiates the contract, is dead when it matures as a death claim and, therefore, cannot give his story of the negotiations in event of dispute over a claim.

7. Although the probability of death at particular ages changes slowly with our development of preventive medicine and other life-prolonging characteristics of civilization, it changes so slowly that it is possible, from past experience, to construct tables, that

measure with reasonable accuracy, for a considerable term into the future, the probability of death at each age of a given type of person.

8. The subject matter of the insurance may change from an asset, against the loss of which insurance is desirable, to a contingent liability to meet which advance provision is desirable; for an individual who is, during his active years, a producer of income for himself and others may live to see the time when he can no longer produce, though he remains to consume. Unless he provides for this in advance, he will be a dependent consumer. Yet he may not live to that time. This need is contingent. The risk involved here is like property risks, a "whether or not" and not merely a "time when" risk. It is also of uncertain amount. One may live to the maximum age attained by human beings, about one hundred years, but one may die within a short time after reaching the age when one must retire.

Effect of These Differences on Forms and Practices.—Such fundamental characteristics of the subject matter cannot but be reflected in the forms and practices of the insurance business. The following are distinctive characteristics of life insurance:

1. All policies are valued policies. The contracts are contracts of indemnity in the sense that only one with an insurable interest in the life insured may take out such a policy, though the insured has been held to have an unlimited insurable interest in his own life and to be free to assign the proceeds of his policy at will. But the contract is not a contract of indemnity in the sense that payment will be made only to the extent of proved financial loss.

2. Policies may be, and usually are, issued covering the whole term of life and are not cancelable by the company.

3. Even though the risk changes each year into a higher hazard class, the policy may be continued at the same rate.[1]

4. On the basis of mortality tables, interest assumptions, and expense estimates, rates are scientifically calculated to remain level at the initial rate.

5. Since a level premium to cover an increasing hazard implies an overcharge in the early years which must be invested and

[1] Some policies are issued on a year-to-year renewable basis, with increased rate each year, but they are not popular.

conserved for later years, there is an investment element in life insurance not found in the other lines. The excess accumulations over current cost are a *reserve* which is scientifically calculable and apportionable to each contract.

6. A wide variety of contracts are in use, blending investment and pure insurance in various degrees.

7. There is no provision for cancellation by the insured, though he may discontinue the insurance by nonpayment of a renewal premium. If he does so, his equitable share of the investment feature (measured by the reserve) of the contract is made available to him, this share being called the *cash value* of the policy.

8. Since the policy is a valued policy covering total loss (death) only, there is no need, in establishing a claim, to prove more than two things: that the insured is dead and that the claimant is the beneficiary named in the policy. Hence there is no need of elaborate claim procedure, and the policy may be very simple in its provisions for settlement of loss.

9. The insured is usually permitted to change the beneficiary as he desires without requiring consent of the company, though the change may not take effect until the company has been duly notified and formally endorses it upon the policy.

10. The policy contract is *incontestable* unless the insured dies within a fixed period (not more than 2 years) after the policy comes into force.

11. In addition to life-insurance policies providing a sum or sums for the beneficiary on the death of the insured life, annuity contracts are issued providing an income for the holder thereof, as well as endowment-insurance contracts payable in a single sum if the policyholder reaches a specified age.

12. The proceeds of a life-insurance policy may be made payable to the beneficiary as a life income or in installments over a term of years.

13. The policy may, and usually does, provide for selection by the insured or the beneficiary of one of several methods of payment of the proceeds.

Other differences in practice also flow from the peculiar character of the subject matter but do not affect the form of the contract.

FORMS OF LIFE-INSURANCE CONTRACTS

Fundamental Forms.—There are two fundamental types of contracts based upon life contingencies:

1. Insurance, under which the benefit is paid if death occurs within a set time limit, which may include the whole of life.

2. *Endowments* or *pure endowments*, under which the benefit is paid if the life in question survives a set time limit, known as the "endowment period." A series of pure endowments in which the payments are at 1-year or shorter intervals is an *annuity*.[1]

Insurance and endowment may be, and often are, combined in the same contract, which is properly termed a "endowment insurance" but is usually popularly known as an "endowment." Pure endowments are sometimes issued on the lives of children to provide funds for their education, but such a contract is frequently misunderstood on account of the absence of any refund in the event of death before the end of the endowment period; it is now rarely issued except in a modified form providing for such refund.

Term Policies.—Life-insurance policies issued to be payable only if death occurs within a fixed time limit are "term" policies. They are sometimes issued for 1 year only, more often for 5 or 10 years, and sometimes for a longer period, *e.g.*, 15 or 20 years. Until relatively recently, term policies have rarely been written for a period of more than 20 years.

Term policies may be made renewable one or more times at the option of the insured; such policies are *renewable term* policies. They may also provide for conversion within certain time and age limits to another form of policy, without resubmission of evidence of insurability to the insurer; such policies are *convertible term* policies. Term policies may be both renewable and convertible.

Conversion may be made in either of two ways. The more popular way is to have the new permanent policy issued as of the insured's attained age. It is generally permissible, however, to have the new policy issued as of the original date of the term policy and with a premium as of the original age, by the payment

[1] Strictly speaking, this is a *life* annuity. Any series of periodic payments, whether or not contingent upon survival of a life, is an annuity. An annuity, not dependent upon life contingencies, is an *annuity certain*.

of the excess of the premiums on the new policy over those paid on the old accumuloted with compound interest.

As the rate of mortality does not markedly increase with age until beyond middle life, but after that goes up rapidly, it will be apparent that, since a term policy runs but a short time, there is little investment element in it. Consequently, its cost is the lowest of any form of life insurance. It is not, however, permanent life insurance, since on its expiration it can be renewed only at an increased rate.

Term-insurance policies are suitable for furnishing temporary protection to cover a business risk, as for example, the risk a contracting firm runs through chance of the death of its chief engineer before the completion of a particular job. If renewable and convertible, it may be used to protect the family of a young professional man during his years of low income, while building up his practice.

Recently a new form of long-term policy has appeared giving coverage for the life expectancy[1] of the insured. This is considered to be the productive period of life, and it is thought that the need for insurance thereafter will have materially decreased. It may not have entirely disappeared. Consequently, provision is often made for continuance of the policy, at the option of the insured, throughout life at the same premium but in a reduced amount.

The premiums on term policies are payable annually, or at shorter intervals, during the term of the policy.

Whole-life Policies.—Insurances extending over the entire term of life, at a premium rate fixed in advance and named in the contract, are *whole-life* policies or simply *life* policies. The premium may be payable throughout life, or limited to a term of years, or even be made in a single payment. On the basis of these three methods of payment, there are three types of contract: *ordinary-life*, *limited-payment life*, and *single-premium life*. Limited-payment policies may be issued with a premium-paying period of any desired term of years, but a period of 20 years is the most popular.

The ordinary-life policy is the lowest priced form of permanent

[1] The *life expectancy* of a person is the average afterlifetime of persons of his age as indicated by a given mortality table.

life insurance, since its premium is just sufficient to cover the future risk and keep the rate from rising in the later years. It is adapted to the needs of most persons requiring permanent protection. It contains an investment element, since the premium in the earlier years is greater than is necessary to meet current cost, the excess being conserved for future needs.

Reserves.—Though there is an excess charge in the early years to meet the cost of rising mortality in later years, it must not be thought that the reserve on a life-insurance policy increases for a time and then decreases. The accumulated excess charges (reserve or investment element) maintained against any policy to keep future premiums level are, of course, no longer needed when the policy is terminated. If the termination is by lapse or surrender, it may be paid to the insured in cash or used in other ways for his benefit. If the termination is by death, it may be drawn upon to help pay the claim. Thus, if a reserve of $200 has been built up on a $1,000 policy and if the insured dies in the next year, that reserve is no longer required. It is *released*, and its amount is made available toward payment of the claim. The company has only to find $800 ($1,000 less $200) from its current year's premium income. As the reserve increases, this *net amount at risk* decreases. The amount to be furnished from the current premium for carrying the risk of a policy in any year is its share of the *net* mortality losses which is the product of the probability of death by the net amount at risk. Although the probability of death of the insured increases as he grows older, the reserve on the policy also increases and the net amount at risk correspondingly decreases. The product of the two is always less than the premium charged plus the policy's share of interest earned on reserve funds until the age of the insured is so great that death within a year may be regarded as certain.[1] Consequently, there is always some excess in the current year's premium to be added to the reserve. *The reserve under a whole-life policy increases continuously as long as the policy is in force.*

A numerical illustration will perhaps make this clearer. According to the American Experience Table of Mortality and on the assumption that invested funds will yield 3 per cent net interest, the annual net premium required for a whole-life policy

[1] Most mortality tables show this to be about age one hundred.

of $1,000 issued at age forty-five is $29.67.[1] Let it be assumed that premiums are payable annually in advance and that claims are paid at the end of the year in which the death of the insured takes place.[2] Then if the company's mortality experience exactly follows the American Experience Table the average results for several years with respect to such a policy will be as shown in the following table:

ILLUSTRATION OF GROWTH OF LEVEL PREMIUM RESERVE AND ITS EFFECT ON THE COST OF INSURANCE

(1) Duration of policy in years	(2) Age of insured at end of year*	(3) Death rate per 1,000 during the preceding year	(4) Reserve at the end of policy year	(5) Net amount at risk ($1,000 minus the reserve)	(6) Cost of insurance, *i.e.*, amount to be provided out of current premium
1	46	11.16	$ 19.61	$980.39	$10.94
2	47	11.56	39.65	960.35	11.10
3	48	12.00	60.12	939.88	11.28
4	49	12.51	80.98	919.02	11.50
5	50	13.11	102.20	897.80	11.77
6	51	13.78	123.74	876.26	12.08
11	56	18.57	235.35	764.65	14.20
16	61	26.69	350.30	649.70	17.34
21	66	40.13	463.62	536.38	21.52
26	71	61.99	569.69	430.31	26.68
27	72	67.67	589.57	410.43	27.77
28	73	73.73	608.98	391.02	28.83
29	74	80.17	627.98	372.02	29.83

* If living.

Immediately upon receipt of the premium of $29.67, the company invests it at 3 per cent so that by the end of the year it

[1] The gross premium charged will be somewhat larger because it must also provide for expenses, but for the present purpose it may be assumed that the net amount received by the company is the above figure.

[2] These are the usual assumptions in actuarial calculations. Adjustment for the departure from them in practice is made in the loading factor by which the gross premium is built up from the net.

amounts to $30.55. Of this, $19.61 must be put in reserve to help pay future claims, leaving $10.94 available to pay the policy's share of claims the first year. Since the $19.61 will not be required for any given policy's share of future claims if it does not continue to be in force, this sum may be used toward payment of the claim in any case where the insured has died during the year. Hence the amount to be taken from the year's premiums on all policies of this class for such a claim is not $1,000 but $1,000 minus $19.61, or $980.39 [the amount shown in column (5) of the table]. Since 11.16 per 1,000 of the policyholders die, the amount chargeable per $1,000 policy is 0.01116 × 980.39 = $10.94 [the amount shown in column (6) of the table], which is precisely the amount provided by the premium and interest after setting aside the required reserve.

For those policies which begin the second year there is already in reserve $19.61 per $1,000. Adding the new premium ($29.67) to this gives a fund at the beginning of the year of $49.28. With interest at 3 per cent this will amount at the end of the year to $50.75, out of which now $39.65 must be set aside for reserve, leaving $11.10 from each policy to be used to pay the year's claims. But again the reserve of the policies of those who die may be used in part payment of the claim and the net amount [shown in column (5)] on each such claim is $1,000 minus $39.65, or $960.35. The death rate has now increased to 11.56 per 1,000. Hence the amount required from each policy's premium is 0.01156 × $960.35, or $11.10, the amount available as shown above. Accepting the figures in columns (3) and (4), the other figures in the table may be similarly verified.

The table, prepared in this way, shows that, as the rate of mortality increases, the net amount at risk (pure insurance) decreases in a compensatory manner by reason of the increasing reserve (savings fund) so that the cost of the insurance increases much more slowly than the rate of mortality and always stays less than the premium plus the policy's share in interest earnings. It will be noted that not until after the policy has been in force 29 years does the "cost of insurance" exceed the premium.

Similar tables may be prepared for any plan and age at issue. On endowment-insurance policies, since the face is payable at the end of a term of years if the insured survives, as well as at death

if it occurs in the interim, the reserve (savings fund) must build up more rapidly, the net at risk correspondingly decrease, and the cost of insurance be still lower.

The precision shown by the table is not realized in practice. Nor is such precision necessary. Surplus funds take up the differences and are periodically distributed to policyholders or stockholders as dividends. The important thing for the student at this point is a clear understanding of the principle involved.[1]

Unfortunately, many who take out level-premium life-insurance policies fail to appreciate the function of the reserve and its equivalence to a savings fund. They do not realize that the life-insurance company cannot furnish a uniform *net* amount of insurance without charging an increased rate. Consequently, when a so-called "analyst" points out that the reserve is their money and that they are paying a uniform rate for a decreasing amount of pure insurance, they feel that they have been deceived and unjustly treated. They listen to his siren song that they may more profitably keep their own savings fund and take decreasing term insurance to keep the same net estate, forgetting that if the savings fund is really to be such it cannot be used for current enjoyment. All too often the victim takes his cash value (the analyst approaches only those whose policies have been in force long enough to build up a substantial reserve), uses it for business purposes, fails to keep a savings fund intact or loses it through poor investment, and finds his program for creating an estate for his dependents or his own old age in ruins.

It is because of such misfortunes, which arise from a lack of clear perception of the savings nature of the reserve and its necessity as a means of keeping life-insurance premiums level, that it has seemed wise to make this long excursus into the subject of life-insurance reserves.

[1] These calculations have been made on the mortality and interest base formerly in common use by life-insurance companies. The necessary values for checking them are available in numerous publications. More recently the companies have based their calculations on a more modern table and a lower interest rate. The use of such a basis would change the values shown but not the relations. Since the calculations are inserted only to illustrate the principle involved and can be more readily verified, by others than actuaries, than if they were on a currently used basis, they have been retained from the previous editions of this book.

Nonforfeiture Values.—If the insured wishes to discontinue the insurance, he may cease to pay the premium, and the law requires that the policy provide that the amount of this reserve (investment element) or the major portion of it[1] be used for his benefit. These benefits are *surrender* or *nonforfeiture values.* They do not generally become available before the end of the second year. A number of optional forms of such values are given. The cash value increases with the age of the policy because of the increase in reserve and because a larger portion of the reserve is so used. Usually the other nonforfeiture benefits also increase but at a lower rate since the increasing age of the insured reduces the benefit a given amount of cash value will buy.

Some persons are unwilling to take ordinary-life insurance because of the fear of having to pay premiums in old age.[2] It is for such persons that limited-payment forms are designed. Since there is a time after which further payments are not required, it must be apparent that the investment element in the limited-payment policy is much greater than in the ordinary-life policy. This form is particularly suited to those whose earning power may be reduced after a time, and who consequently wish to get the expense out of the way before that time comes. The difference in the term for which premiums are payable, the higher premium payments, and the higher surrender values are the only differences between the ordinary and limited-payment life forms.

[1] Since it is optional with the insured to continue or surrender his insurance and since the insured in poor health will be ill advised to surrender, it may be expected that those who surrender will on the whole be better risks than those who continue. Such consequence of the exercise of options by the insured is *adverse selection.* To offset this the company is allowed to retain a portion of the reserve as a *surrender charge.*

If the company wishes to keep the same volume of business in force to keep the spread of risk and expense, it must replace the withdrawing policyholder. Recoupment of the expense for so doing is another purpose of surrender charge.

[2] Of course, this is not necessary. Whenever the need for insurance ceases, the policy may be surrendered for its cash value. If the premium becomes burdensome in later years and some insurance is still needed, the policy may be exchanged for a paid-up policy of reduced amount, or it may be continued as paid-up term insurance for its face amount for the full term the cash value will provide. See p. 181.

Endowment Insurance.—Endowment insurance is a combination of insurance and endowment, of a term insurance for a specified time and pure endowment for the same period. It is, therefore, payable at its face if the insured should die within the endowment period, and at the end of the period if the insured is alive. Since the insurer, the company, must have the money in hand to pay at the end of the endowment period, there is a larger investment element in this form than in either of the others considered.[1]

In European countries, where the habit of retiring at a fairly early age to enjoy life is well established, endowments are popular and are usually issued to mature at a fixed age. Some policies maturing at a fixed age are offered in the United States,[2] but it is a more usual practice to make the endowment period a fixed term of years. Twenty years is the most common term, though longer and shorter terms in multiples of 5 years are also issued. Most endowment policies are issued with a premium-paying period equal to the endowment period. But they may also be issued on a form limiting the payments to a shorter term of years.

There is little difference in the form of endowment and life policies, merely an added phrase reciting the requirement to pay the insured if living at the maturity date, and a slightly different schedule of nonforfeiture values.

Annuities.—Until recently, annuities were not in much demand in the United States. Americans looked forward to "dying in the harness." The struggle was not to attain a competence on which to retire and enjoy life but to amass a fortune to pass on to one's heirs. The tendency of corporations to replace private business firms, changing the proprietor to a corporation official subject to retirement as his powers fail, the growing realization that only the lucky few can amass fortunes, as well as losses of investments in times of depression, have brought a change of attitude. The demand for annuities has been growing, particularly since the depression of the thirties.

Annuities may be, and until recently usually were, paid for by

[1] Endowment insurance is susceptible to the same analysis as that made above for ordinary-life insurance; it likewise is a combination of a savings fund and pure insurance.

[2] In recent years these policies have become increasingly popular.

a single premium.[1] Such annuities were bought for elderly persons, usually women, who had a modest fortune from the care of which they wished to escape with an assured income for life. They may also be paid for by an annual premium payable over a term of years, the beginning of payments under the annuity being deferred until the end of the premium-paying period. These are *deferred annuities.* This is the form suitable for an earner looking ahead and providing for his own retirement. The forms used for single-premium annuity contracts are fairly simple, merely reciting the company's obligation to pay the annuitant if living, and the form of proof required that the annuitant is living.

The cupidity of human nature is such that most people object to purchasing simple annuities. They feel that if they die within a short time their estate will have been robbed of the difference between the consideration they paid and the amount paid them in income. To meet this objection *refund annuities* and *cash-refund annuities* are offered. Under the former the income is continued until the total amount paid equals the consideration. Under the latter the difference between the consideration and the income drawn is paid at the death of the annuitant. Obviously less annual income can be paid under a refund annuity than under a simple annuity, and still less under the cash-refund form. The contract is a little more elaborate under the latter forms since it must define precisely these additional obligations of the company. In recent years the prices of annuities have been rising, owing to two forces: (1) the decreasing interest rate which the companies are able to obtain on long-term safe investments and (2) the increasing longevity of annuitants, free as they are from the strain of earning a living. The table on page 171 shows the annual income obtainable from $1,000 invested in 1945 in the several types of annuities.

There is some difference in the rates quoted by the various companies, and some companies issue participating annuities

[1] Because of the investment problems created by the receipt of large sums in single premiums and the increase in cost of furnishing annuities due to increasing longevity, many companies have ceased to sell single-premium annuities.

ANNUAL ANNUITY PURCHASED BY $1,000
(Nonparticipating)

Age	Type of annuity		Cash refund
	Regular	Refund	
Male:			
50	$49.96	$43.30	$42.12
60	66.13	52.52	50.18
70	94.89	66.24	61.36
Female:			
50	44.53	39.84	38.99
60	56.96	47.47	45.81
70	78.33	58.69	55.34

with a lower amount guaranteed but with prospects of greater actual return when the dividend is added.

Comparison of these returns with the yield of safe securities shows the extent to which the capital sum paid in is drawn upon in each annual installment.

The lower returns to female annuitants are due to the lower mortality among elderly women than among elderly men.

Deferred annuities, especially those purchased by annual premiums, whether or not of the refund type, usually provide for the refund of the consideration or premiums, with interest, if the contract holder dies before receiving any payments under it. Also, there are nonforfeiture values[1] in event of lapse in payment of any of the premiums.

Uses of the Various Forms.—The premiums charged for the different forms of insurance differ according to the cost of furnishing the benefit and the length of time for which the premium is payable, as well as according to the age of the insured.

The accompaning table shows the rates of a large company issuing only nonparticipating policies. They are typical for such policies. The rates charged for participating policies[2] by companies issuing such contracts are higher but vary similarly according to the form.

[1] See p. 168.
[2] See p. 174.

Comparative Table of Rates per $1,000 for Nonparticipating Life Insurance

Age of insured	Form of policy			
	10-year term	Ordinary life	20-payment life	20-year endowment
25	$ 8.58	$16.56	$28.58	$47.07
35	10.00	22.24	34.50	47.71
45	15.83	32.35	43.49	51.21
55	*	49.49	58.22	61.23

* Not quoted at this age.

If life insurance is needed for a limited time, and the need then ceases, *e.g.*, in the case of a corporation undertaking a large construction contract and relying on the skill and experience of a directing engineer, term insurance meets the entire need and is cheapest. It is rather a poor choice for the average man of family. Usually his need continues for the greater part of his life. The cost of term insurance increases each time it has to be renewed, and after certain ages are reached it cannot be renewed, although he can get more insurance for the time being for the same money. The young professional man with high need and low present income, but excellent prospects of better income in the future, can use term insurance to advantage.

For most people ordinary-life insurance is most satisfactory. The rate is higher than for term insurance and, as an inspection of the table shows, only about half as much can be carried for a fixed annual sum as if 10-year term insurance were taken. But the rate is fixed for the remainder of life, and the insurance can be carried for the whole of life. The rate on the limited-payment form is again higher, and the same outlay will provide less protection, but the premiums stop after a given number have been paid. This appeals to many persons who feel they want to get the payment over with. Critical analysis raises a question whether this is usually as beneficial as the larger sum purchasable if the ordinary policy were taken. If there is an adequate income for a time with prospect of diminution later, this form is desirable. With most persons the reverse is more probably the case. About 75 per cent of the life insurance in force of companies doing busi-

ness in New York state is on the whole-life (including ordinary-life and limited-payment policies) form.

Endowment insurance is designed to furnish at least a fixed sum at a definite future date regardless of the life or death of the individual insured.[1] For example, members of college classes have taken out such policies to provide gifts to their alma mater on the twentieth or twenty-fifth anniversary of their graduation. If the premium payments are kept up, the money will be there whether the individual lives or dies. Such a policy may be used to fund a debt maturing at a future date, or to provide for the education of a child. Still less can be provided for a fixed annual sum than on any of the other forms. For individuals who find it difficult to save, the requirement to meet a fixed payment is often a corrective, and the endowment policy is desirable for such a person. If death occurs during the endowment period, only the face is payable. Therefore, a person who will save regularly will leave more to his estate by purchasing the same amount of ordinary-life insurance, putting the remainder in a sound savings institution, and leaving it there. It is so easy to withdraw it, that few do the latter. Still more will be left to the estate if the entire premium required for the endowment policy is used to buy ordinary whole-life insurance.

One common fallacy is that one must "die to win" under an ordinary-life-insurance policy. This is not so. It is true that the policy is not payable for its face value until the death of the insured. It is also true that it contemplates payment of premium throughout life. But whenever the need for the insurance ceases, the policy may be surrendered and the surrender value taken in cash.[2]

In planning the life-insurance program for an individual, several things must be considered:

1. His need for life insurance. This will depend among other things upon the size of his family, the age and health of his wife, children, and others dependent upon him, upon the standard of living to which his family is accustomed, and upon the extent of

[1] Since the amount paid at the death of the insured will presumably earn interest, the amount available at the future date may actually exceed the face of the policy.

[2] See note 2, p. 168.

his resources independent of earning power. The need of cash to pay inheritance taxes should not be overlooked.

2. His income and how it may change in the future. Important as it is to provide for dependents after the death of an individual, the cost of that provision always causes some reduction in the capacity to provide in the present. If the present sacrifice is too great, the whole insurance may be allowed to lapse. A program calling for a less outlay may be carried through. There is always the balancing of present and future sacrifices. The adaptations of forms to income changes has already been noted.

3. His temperament. This point has been touched upon in the discussion of the use of the endowment forms.

4. The nature of his financial obligations and the financial capacity of his dependents. These factors influence both the amount of insurance to be carried and whether it should be made payable in a lump sum or in some other manner and, in the latter event, in what manner the best results will be obtained.

Participation in Earnings.—Since, as must be evident from reflection on the nature of the insurance business as presented in Part I, there is a large element of mutuality in all insurance, it may be anticipated that many insurance carriers will be mutual corporations in form. The form of organization of insurance carriers will be treated further in Part III, but it is desirable to note here that, far more than in other fields, life insurance is conducted by mutual companies. Hence, it is usual to find in life-insurance policies a prominent place given to clauses providing for participation in the earnings[1] of the corporation. Further reference to these will be made at the proper place.

Standardization of Forms.—Prior to 1907, life-insurance forms were not standardized by law, either *in toto* or in requirements for particular provisions, save for the statutory requirement of

[1] Since a life-insurance company, if it does any other kind of insurance business, must keep its life-insurance funds separate, these earnings can arise only because the insurance furnished the policyholders has cost less than was charged them. They are, therefore, in the nature of refunds of excess charges and not earnings in the usual commercial sense. This is as true in the case of a mutual company as in the case of a stock company issuing participating policies.

nonforfeiture values, and the specification of the reserve basis for them. But during 1905 and 1906, there was a thoroughgoing investigation of the conduct of the life-insurance business by a committee of the New York Legislature. On the recommendation of that committee, which had uncovered many abuses, a statute was passed prescribing standard forms of policies to be used by all companies doing business in that state. The insurance commissioners and attorneys general of other states met in conference at the same time and appointed a Committee of Fifteen to study the matter further. This committee recommended against the requirement of standard forms, and in favor of requiring standard provisions and the prohibition of certain provisions that had appeared. This recommendation, with the requirement of approval of forms by the Insurance Commissioner, has been followed in most states. New York, in 1909, repealed its standard-policy law and enacted the same form of requirement. It is perhaps fortunate for the public that the legislation took this form, for the policies today are distinctly more liberal than the former New York standard.

Plan of Treatment.—As in the study of the contracts in use for other kinds of insurance, the following points will be considered in order:

1. Parties.
2. Consideration.
3. Definition of the risk transferred.
4. Conditions relating to payment of loss.
5. Other clauses.
6. Modification of the policy form by endorsement.

Parties.—There are usually three or more parties to a life-insurance contract: the issuing company, the insured on whose life the policy is issued, the beneficiary who is to receive the proceeds of the policy, and sometimes one or more contingent beneficiaries who succeed to the right of the beneficiary if they survive him. Unless it is otherwise provided in the contract, the beneficiary's interest becomes vested at the issue of the policy. It is the usual present practice to provide that during his lifetime the insured may exercise any and all rights under the policy, including its surrender, without the participation of the beneficiary. Where, as in policies issued 35 or more years ago,

this right is not reserved, the beneficiary must join in applications for loans and surrenders if the company is to be safe from double claim. Until about 35 years ago policies seldom provided for change of beneficiary except by reason of the death of the named beneficiary, whose rights passed to named contingent beneficiaries in succession. Most policies now reserve to the insured the right to change the beneficiary at will.[1] He can, however, at the time of application make an irrevocable designation and thereafter will not have the right to change.

Consideration.—Unlike the practice in other kinds of insurance, life-insurance policies are not issued by agents but by the home office only, and on the basis of a written application which is made a part of the consideration for the contract. The application is in two parts: the first, or application proper, which is taken by the agent, identifies the insured and indicates the kind of policy desired, its amount, the name of the beneficiary, and other facts required properly to write the policy; the second, or Statements to the Medical Examiner, contains the applicant's representations with regard to his past history, habits, physical condition, and other factors indicating the character of risk he is likely to be. Under the standard-provisions statutes in most, if not all states, the policy constitutes the entire contract, and in order to bring in the application as a part, a copy, usually photostat, is attached to the policy. In most states, it is prescribed by statute that the statements of the insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement may be used in defense of a claim unless it appears in the copy of the application.

The premium and its periodic payment are also a part of the consideration for the contract. Some companies make the policy a receipt for the first premium; others do not. Premiums may be made payable annually, semiannually, quarterly, or with some companies, monthly.

Since the premium is based on the age of the insured, it is important that it be correctly stated. One of the statutory standard provisions is that, if the age has been misstated, the amount of the policy shall be such as the premium would

[1] Community property laws in various states are now limiting this right where wives are named as beneficiaries.

have purchased at the true age of the insured according to the company's regular scale of rates for the same kind of policy.

Risk Transferred.—The definition of the risk transferred under a life-insurance policy is quite simple. The policy is in the form of a conditional promise to pay, the condition being the receipt of due proof of the death of the insured and surrender of the policy properly receipted, except in the case of an endowment or a term policy. In the former, the promise is to pay the insured if living on the maturity date of the policy, or on receipt of due proof of the death of the insured before that time to pay to the beneficiary. In the latter, there is inserted, after the name of the insured, language to indicate that the death must have occured prior to the expiration of the policy.

The term of the policy is further limited by the requirement for regular payment of premiums, it being provided that the payment of any premium shall not continue the policy in force beyond the due date of the next premium.

Formerly, the risk of travel and residence in certain parts of the world were not assumed under the policy, but most modern policies are free of such restrictions and, to emphasize the change, it is usually so stated in the policy.

Suicide within one year from the date of the policy is a risk not assumed.[1] The clause may appear unduly harsh on account of the presence of the words "sane or insane" in connection with the suicide. This language is due to the decision of some courts that suicide is itself proof of insanity. The clause is a method of controlling moral hazard. It is not generally believed that there is much likelihood that a person contemplating suicide and desiring to protect dependents will take out a policy and wait a year or more before carrying out his intention.

By custom and statutory requirement, the policies are made *incontestable* after one or two years from the date of issue, except for nonpayment of premium. Consequently there can be no limitation on the risk except within this period. Some companies make suicide the only exception even within this period. But others, by an agreement provision in the application and reference on the policy, exclude the hazard of certain occupations during the first year. The occupation of the insured is

[1] The policies of some companies specify 2 years.

carefully examined in passing on the application, and his past occupations and expectations of change are carefully inquired into. It is generally felt that a change, even to a highly hazardous occupation after a year's duration, is a risk the company should assume. If the conditions at the issue of the policy point to the likelihood of such change, an extra premium may be charged or the risk declined.

The standard-provisions statutes permit as an exception to the incontestable clause military or naval service in time of war. Most companies, however, did not make even this an exception until the outbreak of the Second World War. The military forces are usually drawn from the younger and uninsured classes and, should more insured be drawn in a later war, undoubtedly the government would make provision for assuming the war risk. Sanitation in modern warfare has reduced the war risk from disease to as little as, or less than, the risk of disease in civil life.[1]

Provisions Relating to Loss Payment.—Endowment policies are payable to the insured, if living, at the end of the endowment period. Except for this case, life-insurance policies are payable to the named beneficiary. Sometimes there is a contingent beneficiary named to receive the proceeds in the event of the prior death of the named beneficiary; sometimes the interest of the beneficiary reverts to the estate of the insured. In the case of policies or certificates issued by fraternal orders, the statute limits beneficiaries to those having certain family relationships to the insured.

The necessity of presenting due proof of the death of the insured has been noted. No difficulty arises except where the death has been due to a cause that is an exception under the policy and in disappearance cases.

As beneficiaries are usually widows not trained in finance, all too often the proceeds of life insurance of substantial amount have been lost through poor investment. Consequently most policies now contain a number of installment options for settle-

[1] Since the inception of the Second World War the companies have inserted restrictive war clauses, but generally there is no reduction of the amount payable on the death of a civilian from war causes within the continental limits of the United States.

ment, any one of which may be selected by the insured and, if he has made no selection, by the beneficiary. Since, even in the case of a single individual, the way in which it will be best to make payments may well change during the life of a policy, these options permit adaptation to the circumstances. For example, a young man paying off a mortgage on his home may want a considerable amount of his total life insurance payable in a lump sum. After the payment of the mortgage, he may want an adequate, assured income for his widow should he die before the children are educated, payable over the period of time necessary for their education. After the children are educated, the widow needs a life income of smaller amount. All this may be accomplished by filing with the company his election of the appropriate settlement option, changing it from time to time.

The policy contains not only a number of optional provisions for payment of the proceeds,[1] but also other special options that may be granted. Sometimes the desires of the insured are such that discretionary powers must be exercised. Life-insurance companies may not assume such trusts, and it may then be considered advantageous to make the policy payable to a trust company under a *life-insurance trust.* Sometimes trust funds are deposited with a trust company from which to pay the premiums, and the company assumes under the trust the entire management of the insurance and the estate created by its proceeds.

Policy forms have generally provided that, if the premium were payable more frequently than once a year, the unpaid portion of the premium for the current year would be deducted from the face of the policy when payable at the death of the insured. This was on the theory that all premiums were expected to be paid annually in advance and that the acceptance of installments was a special concession to the insured. This practice was often misunderstood by beneficiaries and, even when understood, was a cause of disappointment. Some companies are now omitting this provision and pay the full face of the policy regardless of how premiums are payable. At least one prominent company also refunds a part of the annual premium paid for the year in which death occurs. This is in line with the constant

[1] For further details as to the form of these options in a typical policy, the reader is referred to Appendix XIX.

tendency toward the most liberal contract that can be safely written.

Nonforfeiture Provisions.—A large part of the policy is taken up with the statement of the benefits allowed in event of lapse or surrender of the policy, the *nonforfeiture provisions.* Before discussing these it will be well briefly to review their origin.

In the early history of life insurance, in event of lapse (failure to pay a premium when due), all the equity of the policyholder in the reserve, accumulated to guarantee that the premium on his policy would remain level, was forfeited. This was a gross injustice and hardship, though it was mitigated in many cases by the then current practice of accepting notes for a considerable part of the premium and by allowing them to stand as a debt against the policy, redeemable from dividends when declared. These notes were automatically canceled when the policy lapsed. The harshness and inequity of total forfeiture when premiums had been paid in cash impressed so strongly the Hon. Elizur Wright, first Insurance Commissioner of Massachusetts, that he pressed for, and in 1861 secured, the passage of a law requiring companies doing business in that state to redeem the policyholder's equity in a lapsed policy by granting a value equal to the excess of the reserve over a reasonable charge for disadvantages imposed on the company by the lapse.[1] This equity was not required to be granted in cash, but was to be granted by extending the term of the policy without further premiums until the equity was exhausted. From this beginning in compulsion, competition has tended to center on the liberality of this *surrender* (or *cash*) *value*, and the *surrender charge* which is deducted from the reserve in determining the value has been gradually reduced, and a wide choice given the insured in selecting the benefit best suited to his case. This condition would undoubtedly have come about in time, but the name of Elizur Wright is greatly esteemed for his initiation of this reform, as well as the requirement of adequate reserves for all life-insurance companies.

Although not grouped together in the contract there are

[1] Unless the company is to decrease in size and lose public confidence, it must secure a new policyholder to replace the one lost. This involves expense, and the extra expense should be borne by the withdrawing policyholder and not by the body of persisting policyholders—the company.

three provisions that may properly be called "nonforfeiture" provisions:

1. A *grace* of 31 days (sometimes 30 days or 1 month), without interest charge, is now usually granted for the payment of any premium. The standard policies proposed in 1907 provided for 1 month at 5 per cent. Under competitive conditions, the irregular length of our calendar months led to the change first to a period of 30 days and then to 31; later the interest charge was waived.

2. *Nonforfeiture Values.*—The insured is given the choice of receiving his equity under the policy

   a. In cash as a surrender value.

   b. In a *paid-up* policy, of a reduced amount, payable on the same terms as the original policy, without further payment of premiums. The amount is fixed by using the cash value as a single-premium payment for a whole-life policy or endowment, if such were the original policy.

   c. In *extended-term* insurance, the policy being carried in force for its face amount for such further term as the cash value, used as a single premium, will cover.[1]

The value of these benefits each year is usually shown in a schedule in the policy, and it is provided that, if the insured exercises no option, a specified one, usually extended-term insurance, will be granted automatically.

As the equity is in the policy, it may be used as the basis of a loan from the company. The policy guarantees the insured the right of such a loan in an amount not exceeding the cash value at the end of the term to which premiums are paid, but subject to payment of interest to that date. These values are indicated in the same schedule.

In some cases, the policy provides that, if a premium is not paid when due, the company shall automatically advance the premium as a loan against the policy until the total of loans and interest equals the reserve, at which point the policy automatically terminates. The policy is not carried so long a time in this

[1] The extension under an endowment policy does not run beyond its maturity date. The equity remaining after providing for term insurance to that date is paid in cash.

way as under the extended-insurance benefit, but there is the advantage to the insured that the policy technically never lapses and that he may resume payments at any time, either repaying the advances or letting them stand as a loan. He may do this regardless of his state of health; to reinstate a policy that has actually lapsed, evidence of continued insurability is required.

3. *Reinstatement.*—Unless the policy has been so terminated that the policyholder has no remaining equity, *i.e.*, surrendered for cash or carried as term insurance and the term expired, the insured may reinstate a lapsed policy in its original terms by paying his arrears of premiums and interest thereon and by submitting satisfactory evidence of insurability.[1]

Miscellaneous Clauses. *Assignment.*—The policy usually contains a clause dealing with the right of the insured to assign the policy. This is designed not to extend or restrict the policyholder's right, but to free the company from responsibility for passing on the validity or effect of an assignment and to give notice that the company is not charged with notice of the assignment until the original or a certified copy has been filed with it.

Dividends.—If the policy is in a mutual company,[2] the policyholder is entitled to share in the surplus earnings[3] of the company, and a clause specifies how often the share (*dividend*) shall be given and in what form. It is now almost universally the custom to apportion the surplus annually, though a dividend is not usually granted before the end of the second policy year, and to allow four options as to the mode of payment. The dividend may

1. Be received in cash.
2. Be used toward the payment of premiums.
3. Be left on deposit with the company at compound interest.
4. Be used to purchase a paid-up addition to the face of the policy payable under like terms and conditions.

[1] The period during which reinstatement is permitted is usually limited to 5 years. The insurer may permit reinstatement after that period, but the required payment of premiums and interest is usually so large that it does not appear advantageous to the insured. The advantage to the insured of such a clause is that the courts have held that the standards of insurability for reinstatement cannot be more severe than those in effect when the policy was issued.

[2] See Chap. XVI for discussion of forms of companies.

[3] See footnote p. 174 as to the nature of these earnings.

Any cash sum, if used as a single premium, will buy a certain amount of life insurance on which no further premiums are required. Option 4 means that the dividend will be used in this way. Thereafter, when the insured dies, the amount payable is more than the original face of the policy. It is as though he held two policies: one for the original amount and a second for the amount bought by his dividends. This calls for a correspondingly higher reserve. If for a number of years the dividends are so used, the reserves on these additional amounts of insurance may equal the difference between the reserve on the original policy and its face value. If so, the company is in position to pay the insured the face of his policy if he cares to surrender it. In the same way the deposits under option 3 and their accumulated interest may in time equal the difference between the reserve on the policy and its face and permit redemption of the policy in cash.

For these reasons, it is frequently provided that, if either option 3 or 4 is exercised, when the total credit to the policy, including the reserve on the original policy and the credits either of dividend deposits or of reserves for the additions, equals the original face of the policy it may at the option of the insured be matured as an endowment. There is also a provision that when the total credits equal the sum necessary at the insured's attained age to pay for the named amount of the insurance, the insured may elect to cease payment of premiums and have the policy continued as fully paid life insurance for its face amount payable at death, or at the insured's election at any time payable for a less amount as a cash surrender value.

Some stock companies, issuing only nonparticipating policies, finding the gradually reducing premiums of the participating companies attractive and, appealing to the vanity of the individual who gets a certain satisfaction from cutting coupons, insert in their policies a sheet of coupons similar to the coupons on a bond, and provide much the same options for the use of these as for the dividends of the participating company. The policies are frequently spoken of as "guaranteed-dividend" policies. This term is a misnomer as the coupon is in no sense a dividend from the profits of the business, but a cash reduction in the premium provided for when the whole scheme of premium payments

was worked out. There is nothing illegal or immoral in this practice if the insured knows what he is getting.

In a somewhat similar case is the practice, sanctioned by the law of many of our states, of depositing with the state insurance commissioner securities equal to the reserve on some or all of a company's policies, registering the policies, and carrying on the face of the policy a certificate to that effect over his seal and signature. If the company's officials are not trustworthy, there may be some gain in the securities not being in their possession, but that is about the only gain from the practice. The uncritical purchaser often takes the seal and certificate as equivalent to a guarantee of the company and policy by the state, and all too often the agent selling the policy makes no effort to disabuse his mind, or may even gently insinuate the idea. In some cases the literature of companies has implied a state guarantee. This is misrepresentation. The laws permitting this practice have been passed to assist the development of local companies whose investments it is hoped will help build up the state.

The laws of most states providing for registration require that if a company registers any of its policies it must register all, but they permit abandonment of registration at the option of the company. Deposits equal to the reserves on policies that have been registered must be maintained as long as they remain in force. The statutes usually limit the type of securities that may be deposited more closely than they do the general investments of the company. Hence, if a weak company has abandoned registration, its best assets are apt to be found in such deposits.

In the case of certain companies which became insolvent during the depression of the thirties, the holders of registered policies were held to be preferred creditors. This imposed greater hardships on the holders of later issues, which were not registered, than would have been suffered had all been treated equally. The unfairness of their situation was enhanced because these policyholders had not been informed of the existence of the preferred class. It would appear that the failure to disclose the existence of these priority rights was a concealment entitling the policyholder to rescind his contract and demand his equitable rights.

The question was not raised, however, probably because under the circumstances the remedy was worthless.

For these reasons the wisdom of legislation providing for registration is open to the gravest question. In several states the provisions for registration have been repealed as to future policies.

Special Accident and Disability Benefits.—In a different class, though due to the same cause (keen competition), are the clauses often found in present-day policies giving a benefit if the insured shall become totally and permanently disabled, or giving additional benefits if death occurs from certain accidental causes. These import into the policy a limited accident and health coverage, for which an extra premium is charged.

The first named of these benefits for the insured is a desirable supplement to a life-insurance policy. It is intended as a benefit for total-and-permanent disability, but the most liberal clauses now provide that total disability for 120 days will initiate payment of the benefit. The benefit promised is usually waiver of premiums on the policy. Sometimes there is also a promise of a payment of ½ per cent of its face value each month, without reduction of the amount payable at death, or requirement of repayment even though the insured recover. As real total-and-permanent disability is, in a sense, a living death, this is a natural extension of the policy which, by removing financial worries, has in many cases assisted in the recovery of victims of tuberculosis and other like diseases.

Liberalizing court interpretations and adverse experience, particularly in the early stages of the depression, led to a general revision and restriction of disability clauses in 1932. There is now considerable diversity in the clauses used. Some companies offer only the waiver-of-premium benefit and require a 6-month rather than a 120-day waiting period. Others have continued the income benefit reduced from the former 1 per cent of the face to ½ per cent and have extended the waiting period to 6 months. Although formerly the benefit was granted for disability occuring before age sixty, now the limiting age is usually fifty-five years. If the benefit is granted to women at all, it is even more restricted. It is most unfortunate that the cupidity of some of the public has

prevented the companies from continuing to grant the more liberal benefit for real cases of permanent-and-total disability.[1]

The second type of accident benefit is usually a provision that double the face of the policy will be paid in the event of death from accidental causes. In some policies there is a clause tripling the benefit in event of death from a limited number of special types of accident, *e.g.*, automobile accidents. The required extra premium charge is small and uniform at most ages. The inclusion of such a benefit is optional with the insured. It appeals to the imagination and is often an attractive selling point. It is not open to the criticism applicable to coupon dividends and registered policies. If it leads to the sale of more life insurance, it probably serves a useful purpose even though the logic of its inclusion in a life policy is debatable. It seems likely, however, to divert the attention of the head of a family from his duty to provide adequately for the future welfare of his dependents and to help salve his conscience for a less adequate provision because a chance is given that it may become redundant if he dies from a particular cause.

Industrial Life Insurance.—Certain life-insurance companies, in addition to issuing the types of policies discussed, issue policies of small face value on which the premium is payable weekly and is collected at the door by the agent of the company. The insurance is intended to provide the industrial classes with funds for funeral expenses, and policies may be issued to all members of the family, including children. The policy forms are similar but much simpler than those in use for larger amounts. The premium is the unit, the face being adjusted to it according to the age of the insured. They are issued in premium units of 5 and 10 cents per week.[2]

Fraternal Insurance.—Many fraternal orders insure the lives of their members.[3] In former years this insurance was on an unsound basis and, although the orders furnished cheap protection while they lasted, their inevitable failure caused much

[1] For fuller discussion of this matter see J. B. Maclean, "Life Insurance," 6th ed., Chap. XIV.

[2] For an extended treatment of industrial life insurance see, Malvin E. Davis, "Industrial Life Insurance in the United States."

[3] See pp. 285–287.

disappointment and suffering. In recent years, efforts have been made with considerable success to save the fraternal system by subjecting it to wise control and by gradually putting it on a sound foundation. The fraternal contract is evidenced by the membership certificate, but the real contract includes the by-laws in which its essence usually is to be found. It will be impossible here adequately to treat this form of insurance. The prospective member should examine the by-laws with care and be sure of full understanding of all their provisions, in addition to investigating the financial position of the order.

Most of the substantial fraternal orders now operate on an actuarial-reserve basis and have largely changed their earlier contracts to conform to that basis. In place of the earlier simple form of membership certificate, they now issue policies with nonforfeiture values and with most other provisions contained in commercial life-insurance policies. They cannot legally avoid the inclusion somewhere of authorization of additional contributions from members in event they are necessary to meet their obligations, but this is not conspicuous in the policy. Except for such a provision, the policies issued by fraternals are practically identical with those discussed earlier in this chapter.

Although the fraternal-life-insurance contract has been characterized by fraternalists as an "open contract," meaning that the premium is not fixed even when the order is operating on a reserve basis, and advantages were claimed when some commercial life-insurance companies failed during the depression, those orders on an actuarial-reserve basis do not stress the possibility of additional premiums being called for.

Group Life Insurance.—As a phase of their personnel work many employers have in recent years provided life insurance for their employees. This is usually provided under a 1-year-renewable-term policy in the name of the employer, with provision for the issuance of certificates to the several employees, the insurance being payable to a beneficiary named by the employee. The premium is paid by the employer, though he may by agreement with his employees pay only a part himself and collect the rest from them. The employer also decides what benefits are to be paid, usually varying them with the length of service of the employee. Most of the companies writing group insurance are

licensed in New York, and their policies conform to the law of that state, which is typical of most others. The law requires the following standard provisions:

1. An incontestable clause, which does not differ from that required in ordinary-life-insurance policies.

2. A provision that the rights of the policyholder or of any insured or beneficiary shall not be affected by any provisions other than one contained in the policy or the riders or endorsements thereon or in amendments thereto signed by the policyholder and the insurer, or in the copy of the policyholder's application attached to the policy or in the individual applications, if any, submitted in connection therewith.

3. A provision for a suitable adjustment in event of misstatement of age.

4. A provision that the company will issue to the employer, for delivery to the employee, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom it is payable, and the rights to which he is entitled in accordance with the following two provisions.

5. A provision that in case of termination of employment for any reason the employee shall be entitled to have issued to him by the company, without evidence of insurability, upon application made to the company within 31 days after such termination and upon the payment of the premium applicable to the class of risk to which he belongs and to the form and amount of the policy at his then attained age, a policy of life insurance only, in any one of the forms customarily issued by the company, except term insurance, in an amount equal to the amount of his protection under the group-insurance policy at the time of such termination, and that, if he dies within such 31-day period and before any such individual policy has become effective, the amount of insurance for which he was entitled to make application shall be payable as a death benefit.

6. A provision that, if the employer or the company shall terminate the policy, then every employee who has then been insured under the policy for at least 5 years shall be entitled, upon the termination of his insurance protection under the policy, to the same benefits upon the same conditions and limitations as those provided in the foregoing paragraph for an employee

whose employment is terminated, except that the policy may provide that the amount of such converted life insurance shall in no event exceed the lesser of (*a*) the amount of such employee's life-insurance protection under the group policy at the date of the cessation of such insurance protection less any amount of life insurance for which he may be or may become eligible under any group policy issued or reinstated by the same or another insurer within 31 days after the date of such cessation or (*b*) $2,000.

7. A provision that all new employees eligible for insurance, and belonging to the same class as those insured under the policy, will be added on the same terms.

Group insurance, introduced about 1910, has had a rapid growth, and there are now over 25 billion dollars of such insurance in force. Most of this is on a contributory basis, the employee usually paying 60 cents per month per $1,000, regardless of his age, and the employer the balance of the premium. Although the insurance is on the 1-year-term plan and the premium rate for an individual employee increases each year, the increase in total cost to the employer is relatively small, as the age composition of his staff does not change rapidly. His contribution is, of course, greater for the older than the younger employees, but the contributions of the youngest are little more than the cost of his own insurance. Owing to economies in administration the cost is very low—usually about 1 per cent per year of the total amount insured.

Although the age composition of a staff of employees does not change rapidly, as labor turnover diminishes the average age tends to increase. To the extent that the turnover diminishes after the introduction of a group-life-insurance plan the employer may expect his net contribution to the cost to increase. If, as is sometimes the case, retired employees are continued in the group, the employer's cost increases more rapidly. There is generally a tendency to slow increase as the plan matures.

Group insurance has given protection to large numbers of beneficiaries who would otherwise probably have been left in distress. It is significant that, even in the depth of depression, the total amount of group insurance in force fell only about 10 per cent and by 1935 had passed the predepression level. But it is unfortunate that it is not permanent in character. Few employ-

ees convert to permanent plans when they leave a firm providing them with group insurance.

Group Annuities.—Many firms of the type that carry group life insurance for their employees also make provision for retirement incomes. For various reasons private pension plans have not proved satisfactory, and the life-insurance companies have offered group annuity contracts to take their place. The first such contract in the present form was issued in 1921. The general plan is similar to group life insurance in that a master contract is issued to the employer and certificates are issued to the individual employees.

The problem of accumulating a fund for retirement is so different from that of providing a sum at death that the contracts are much more complex than the group-life-insurance contract. They must specify the age at retirement, usually sixty-five for men and sixty or sixty-five for women employees, the basis of the retirement income, usually 1 or 2 per cent of the employee's salary for each year he contributes, his rights on leaving employment before retirement age, and many other matters. Often the insurance company and employer prepare a booklet descriptive of the plan to be distributed among the employees. Though these plans follow similar general lines, there is considerable variation in details.[1] At the present time over 100 million dollars annually is being paid in premiums on such contracts. The coming into effect of the retirement annuity provisions of the Social Security Act caused considerable modification of these plans to make them supplementary to the provisions of the act.

Fitting the Policy to the Risk.—It is well to close this chapter by again emphasizing the desirability of selecting the particular form of contract best suited to the individual needs of the prospective policyholder. The most successful agents spend much time and effort on this high service to the insured and the community. If the insured has taken the right policy, he will more certainly maintain it to completion, and the loss to the community as well as individual which comes from lapses and surrenders will be saved. So to adapt the policy to individual needs requires a careful study of the prospect's income and

[1] For fuller treatment, see J. B. Maclean, *op. cit.*, pp. 391–397 and Birchard E. Wyatt, "Private Group Retirement Plans."

obligations, and a program looking several years in advance should be worked out.

SUMMARY

1. The risk covered by life insurance is essentially one of the occurrence of an event that *must* happen at some time.

2. The writing of long-term contracts on an increasing risk involves a considerable investment element.

3. The consequent form of contract is essentially different from other insurance contracts. It varies according to the relative importance of the investment element.

4. Forms are not fully standardized, but certain provisions are required. Competition has tended to develop a broad, liberal contract.

5. The consideration for the contract includes a written application as well as the premium.

6. The contract is continuous and is not cancelable by the company, but it may be discontinued by the insured through nonpayment of premium.

7. The benefit is payable to a beneficiary named in the policy, but the insured may change the beneficiary from time to time at his option, unless by making a designation irrevocable he has given up his right.

8. A number of options are granted as to the manner of payment of the proceeds of the policy when it becomes a claim.

9. The contract is incontestable by the company, after a fixed time limit, except for nonpayment of premiums.

10. Liberal surrender options covering the equity of the insured are allowed in the event of lapse.

11. All possible encouragement is given for maintenance of the contract in force to maturity by a liberal grace period and right of reinstatement.

12. If the insurance is participating, the contract gives certain options as to the use of dividends.

13. In recent years, it has become customary to add certain disability and accidental-death benefits, the former of which materially add to the service of the insurance.

14. Industrial-life-insurance contracts do not differ in essence from ordinary policies in common use, though simpler in some

respects. These contracts are designed to furnish the working classes with provision for funeral expense, at a premium rate they can pay.

15. Fraternal-insurance contracts are mainly expressed in the by-laws of the order which, in any individual case, should be carefully scrutinized.

16. Group life insurance furnishes coverage to a group of employees of a single employer under a 1-year-renewable-term policy, for which he pays all or a major part of the premium.

17. In the case of individual life insurance, it is highly important that the contract fit closely the circumstances and needs of the insured.

18. Annuity contracts providing life incomes to their holders are issued by life-insurance companies. They may be purchased by a single premium or by a series of annual premiums paid up to the retirement age.

19. Group-annuity contracts are issued to employers to provide retirement plans for their employees.

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CHAPTER XI

DISABILITY (ACCIDENT-AND-HEALTH) INSURANCE CONTRACTS

Accident-and-health-insurance policies provide benefits payable in case of accidental death or injury of the insured or of disability due to disease. The similarity of the subject matter in these two kinds of insurance is such that they are naturally associated. The accidental-death cover also overlaps in part the coverage of life insurance, and many life-insurance companies have departments conducting these kinds of business. Indeed, as indicated in Chap. X, many life-insurance policies contain disability benefits. With minor exceptions accident-and-health benefits are payable regardless of whether the insured has suffered financial loss, though underwriters aim to keep the amount of benefits within the limits of probable financial loss.

Since it is difficult, if not impossible, to prove objectively the precise time of recovery from many illnesses, and also difficult to prove that illness in a suspicious case is feigned, the companies have found the moral hazard in the health-insurance business serious, and the business has not, in general, been profitable. They have, therefore, made every effort to increase their accident business but have made little effort to write health insurance, except special sickness-expense insurance. In general, health insurance is written only in conjunction with accident insurance, but accident insurance is written freely on a variety of forms to meet the wishes of prospective buyers.

Evolution of the Accident Policy.—The first commercial accident-insurance contracts in the United States (about 1850) were limited to railway accidents defined as "happening to a train whilst in motion." They were issued in the form of tickets covering specific journeys. Later, the policies were broadened to cover accidents from any cause, and tickets are still sold through railroad ticket offices covering for short terms coincident with the probable length of the journey.

Along with the broadening of the contract to cover accident from any cause came a broadening of the sale. Policies were designed not merely for travelers during their journey, but for full-time coverage of various classes of people. Most of the insurance in force at the present time is under policies of this class. The keen competition in the accident-insurance business has led to the introduction of many clauses providing specific benefits presumably highly valuable to the insured. In some of these the value is more apparent than real, *e.g.*, the provision doubling or trebling the indemnity if the injury is caused in a certain way, as while a passenger on a steam- or electric-railroad conveyance. Such provisions came to be known as "frills." Despite efforts to eliminate them in recent years, many of them still remain in the policies. Since the advent of the automobile and particularly its wide popularity and the increase in its accident toll, new limited forms have made their appearance covering only accidental injuries received in connection with automobiles.

Application a Part of the Contract.—Formerly, it was not customary to require the insured to sign an application for a disability policy, but to issue the policy with a schedule of warranties attached reciting that these warranties were made a part of the policy and accepted by the insured. In 1910 and 1911, examination of a number of companies disclosed grave abuses in the settlement of claims by some of them,[1] particularly under limited policies issued on a small monthly-premium basis to members of the industrial classes. These abuses were based partly on policy provisions and partly on the method of issue with attached warranties. Prior to these disclosures there were no statutory prescriptions as to policy forms, but following them most of the states enacted laws requiring certain standard provisions and prohibiting certain others. These laws were recommended by the National Convention (now Association) of Insurance Commissioners, the informal organization of state officials charged with supervision of insurance, and are therefore substantially uniform throughout the states adopting them. One provision of these statutes requires that, for any statement or purported statement of the insured to be used in defense of a

[1] See *Proceedings of the National Convention of Insurance Commissioners*, 42nd Session, Vol. II (1911).

claim, it must be contained in a written or printed application, and a copy of that application must be attached to the policy. Accident-and-health policies are now issued on a signed application which is made a part of the contract, a copy being attached to the policy. Except in the case of the *noncancelable* accident-and-health policy, medical examination is not required, and the application merely consists in a statement of facts by the insured in response to certain inquiries. The inquiries differ with the type of policy and are more extensive in the case of health insurance than purely accident insurance.

Different Forms for Different Classes of Insured.—The risk of personal injury to an electric lineman is much greater than to a bank clerk or similar worker and, although some of this difference may be recognized and provided for in the rate, it would not be feasible to issue to the former a policy form containing as extensive benefits as would be desired by the latter. Consequently, the more hazardous the occupation, the more restricted the form used by the insurer, though all forms must comply with the statutes. The policy analyzed below is a combination accident-and-health policy, issued only to those in the less hazardous type of occupations. Other types of policies differ mainly in the extent of the risks assumed and the size of the indemnity offered.

Parties to the Contract.—The parties to the contract are the company and the insured, though the benefits payable on the accidental death of the insured are payable to the beneficiary named in the application. The beneficiary is not, however, given any further interest in the policy, nor is the beneficiary's consent required to an assignment or change of beneficiary. The insured is identified by occupation as well as by name, and the class in which the occupation is placed by the company is also given for purpose of adjustment in accordance with the policy terms, if occupation is misstated.

Consideration.—The consideration is the premium and the application.

Risk Transferred.—By its terms, a typical policy insures for the term stated:

. . . against loss caused: (1) directly and exclusively by bodily injury sustained, solely and independently of all other causes, through accidental means; or (2) by any sickness necessitating treatment by a

licensed physician and beginning subsequent to 15 days from noon of the date of this policy.[1]

This latter limitation is inserted in the absence of a medical examination to protect the company from claims due to incipient diseases, known to the insured at the time of application but not yet developed, and from claims due to infection from exposure prior to application. Were there no such clause, the companies would find it necessary to insist on a medical examination in all cases, in order to protect themselves against an adverse selection which would give them only the worst risks.

Benefits Payable.—The policy names a *principal sum* which is payable in event of accidental death, and a *weekly indemnity* which is payable during total disability. This makes the contract, like the life-insurance policy, a valued policy. The reason for this is the same as for making a life-insurance policy valued, the inability to place a precise monetary value on human life or soundness of body. Although it is true that, among the industrial classes, it is possible to make a close estimate of actual earnings, it is difficult in the mercantile and professional classes, and it simplifies claim procedure to make the policy valued. This imposes on the company the necessity of seeing that the amount of total indemnity carried by the insured is not too great considering his living standards, else the policy may become a possible source of profit and a moral hazard be created.

There are usually two categories under which the indemnities under accident policies and the accident part of accident-and-health policies are set forth: (1) loss of life, limb, or sight and (2) loss of time. This latter is subdivided into total disability, or entire loss of time, and partial disability, or partial loss of time.

Under the section devoted to loss of life, limb, or sight, there is usually a schedule of indemnities, expressed either in terms of principal sum or weekly indemnity, and payable for each type of dismemberment. Typical of such schedules is the following taken from an accident-and-health policy of a leading company:

Loss of life....................................	The principal sum
Loss of both hands by complete severance at or above the wrists....................................	300 weeks

[1] Quoted from the insuring clause of the policy of a leading company.

Loss of both feet by complete severance at or above the ankles	300 weeks
Loss of one hand and one foot by complete severance at or above wrist and ankle	300 weeks
Loss of entire sight of both eyes if irrecoverably lost	300 weeks
Loss of entire sight of one eye if irrecoverably lost and of one hand at or above the wrist	300 weeks
Loss of entire sight of one eye if irrecoverably lost and of one foot at or above the ankle	300 weeks
Loss of either arm by complete severance at or above the elbow	180 weeks
Loss of either leg by complete severance at or above the knee	180 weeks
Loss of either hand by complete severance at or above the wrist	150 weeks
Loss of either foot by complete severance at or above the ankle	150 weeks
Loss of entire sight of one eye if irrecoverably lost	100 weeks
Loss of thumb and index finger by complete severance at or above the metacarpo-phalangeal joints	75 weeks

Payment will be made for only one of the losses specified in this section on account of injuries resulting from one accident and such payment shall terminate this policy.

The practice being to maintain a fixed ratio of 5 to 1,000 between weekly indemnity and principal sum, it makes no practical difference which unit is used as a basis for the indemnity.[1] To come under this section, loss of limb or sight must be due directly to an accident and occur within a fixed time after the accident. Sometimes the indemnity in the schedule is the exclusive indemnity for the accident.

In the highest priced policies there is payable weekly indemnity for total disability between the date of the accident and the loss in addition to the specific indemnities. The schedule is not cumulative and, if two or more injuries named in the schedule are incurred in the same accident, indemnity will be paid only

[1] Competition, for a time, changed this relation. By 1929 it was common for the accident policy to provide $1,500 for accidental death for each $5 of weekly indemnity, but adverse experience during the depression and the increased fatality rate from automobile accidents have caused a general revision of forms and tended to restore the old relation. See Hart, Ward VanBuren, "Recent Developments in Commercial Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XXI, pp. 291–302.

for the most serious. Payment for any injuries in the schedule terminates the policy. Under the cheaper and more restricted policies there are no alternatives to the schedule; under the higher priced policies, the insured is given the option, in the case of the more serious dismemberments, to be exercised within 90 days of the loss, of receiving in lieu of this indemnity in a lump sum the specific weekly indemnity for total disability so long as he lives and continues to be totally disabled.

The essential requirement in defining the risk transferred under the second category of indemnities is a clear and unmistakable definition of *total loss of time* (or total disability) and *partial loss of time* (or partial disability) and if, as in the more complete policies, different degrees of partial loss are to be recognized, also a clear-cut definition of the several degrees. The definition of an injury causing total disability is such an injury as "shall immediately, continuously, and totally disable and prevent the insured from performing any and every kind of duty pertaining to his occupation," or words substantially similar. Different degrees of partial disability are recognized as inability to perform at least one-half of the work essential to the duties pertaining to his occupation and inability to perform one or more important daily duties.

The indemnity for total disability under the most complete policies is limited only by the duration of disability,[1] but the period during which indemnity for partial disability is payable is strictly limited in all forms.

The doubling feature in event of injuries from certain causes is a frill which it has not been possible to discard. This feature with a varying list of causes is found in nearly all accident policies. Examination of the causes of accidents that will entitle the insured to *double indemnity* will disclose that these events are so spectacular in their nature as generally to be given considerable publicity, but they are of comparatively rare occurrence.

Whether freezing, asphyxiation, blood poisoning, and hydro-

[1] Recently there has been a tendency to limit the indemnity for inability to perform the duties of *his* occupation to a period of 52 weeks but continue the indemnity beyond that time if he is unable to perform the duties of *any* occupation. *Ibid.*, p. 292.

phobia are accidents within the meaning of an accident-insurance policy, and whether indemnity is therefore payable for loss resulting from them, is a question about which there has been much dispute in the past. Modern policies attempt to settle this by provision in the policy. The usual provision is that these injuries, if of accidental origin, are within the coverage of the policy.

Corresponding to the option of the insured to take the disability indemnity in lieu of the specific indemnity for loss of limbs or sight, there is often an optional single-payment benefit in lieu of the disability benefit for the more common types of dislocations and fractures. The option, however, must be exercised within a very restricted time limit, otherwise it would be used to the disadvantage of the company, those whose cases indicated a more prompt than average recovery choosing the lump sum (which corresponds approximately to the average indemnity payable under the disability feature), while those whose recovery could not be predicted within such a limited time would take the benefits under the disability provisions. Even under close restrictions, such optional provisions generally are found to be exercised to the disadvantage of the company.

Accident policies do not generally provide medical treatment, but it is sometimes provided that, if no other benefit is claimed, medical expense will be paid up to the limit of the indemnity for one week's disability. Under some policies, however, surgical benefits, in amounts varying with the type of operation, and set forth in a schedule in the policy, are paid by the company in addition to all other benefits. An additional indemnity for necessary hospital or nursing expense, limited in amount of both weekly benefit and time, is sometimes also given. Another additional cost assumed under many policies is the expense of communicating with, and placing the insured in the care of, friends or relatives. Although these appear to be additional benefits to the insured, it is well to remember that, in cases of serious injury, the duration of disability is usually materially cut down by prompt and adequate medical and surgical attention.

The indemnity furnished under the health policy is for disability from sickness contracted during the term of the policy. Total disability is defined as under the accident policy. Indem-

nity is usually limited to a period of 52 weeks. Sometimes an additional period is covered. For example, under one form in common use, if blindness or paralysis results, an additional sum is paid at the end of the 52 weeks, to make the total equal the indemnity for 100 weeks' disability. The surgical- and hospital-expense benefits previously referred to under the accident clauses are also usually granted under health policies, and under the sickness disability provisions of combined health-and-accident policies.

The increasing tendency to use hospital facilities for the care of the sick and injured has made the prospective hospital bill an important cause of worry to the victim. Moreover, the persons whose occupations are in the classes to which liberal accident-and-health policies are offered are usually salaried workers whose salaries go on, at least for a time, in event of disability. Hence their need is for hospital-expense indemnity rather than indemnity for lost time. Since the disability policy is valued and the benefit is payable regardless of the insured's other income, it often provides the funds for this hospital expense. But there has been an increasing demand for a hospital-expense policy, and the companies are meeting it in two ways. Some companies have replaced the specific hospital benefits by a provision that the company will reimburse the insured for the amount actually expended by him for such services, not exceeding specified limits. Other companies are issuing policies without death benefit or loss-of-time benefit but providing hospital-expense indemnity with or without specific dismemberment benefits. These policies are not valued policies, except for the specific dismemberment benefits, but are strict contracts of indemnity. There has been some effort to contract to provide the services rather than indemnity for their cost. This could probably be done more cheaply but is generally prohibited by laws forbidding corporate practice of medicine.

Schedule Policies.—To meet the demand of insureds desiring a simpler accident policy without some of the elaborate benefits of the usual commercial policy, a few companies have recently introduced a form commonly called a "schedule policy," which sets up the benefit provisions above described in separate numbered

sections. Its insuring clause contains the following typical provision:

The insurance afforded is only with respect to such and so many of the coverages as are indicated by a specific amount or the word "covered" set opposite thereto:

Section	Coverage		Amount of coverage
1	Loss of life	Principal sum	$
2	Dismemberment and loss of sight	Capital sum	$
3	Total disability	Weekly indemnity	$
4	Partial disability	Weekly indemnity	$
5	Specific indemnity		
6	Double indemnity		
7	Full medical indemnity	....	$
8	Specified medical indemnity		
9	Identification	....	$100

This is a very flexible policy and permits the insured to select and pay for only such benefits as he feels fits his case. Thus, if he has adequate life insurance, he may consider a death benefit under an accident policy undesirable. He may regard double indemnity as a mere frill. He need not take either and does not have to pay for what he does not want. This seems to be a step in the right direction and may, in time, lead to the discarding of provisions which, on critical analysis, seem of more value as talking points for a glib salesman than as solid protection to the policyholder.

Excluded Risks.—Certain risks are definitely excluded from the scope of all accident policies. These exclusions, if the risk is apparently within the scope of general provisions, are required by the standard-provision statute to be printed in bold-faced type.

The most common exclusions under accident policies are

1. Suicide or attempt thereat whether the insured is sane or insane.
2. Injuries
   a. Received while engaged in aerial navigation.
   b. Caused by war or act of war.

c. Caused by ptomaines or by bacterial infection (except pyogenic infections occurring simultaneously with and through an accidental cut or wound).
d. Caused by sickness of any kind.

Health policies also exclude sickness

1. Contracted prior to the date of the policy.
2. Suffered while the insured is entitled to indemnity for accidental injuries.
3. Suffered outside the limits of the United States, Canada, or Europe.
4. Suffered while engaged in military or naval service in time of war.

Limited Contracts.—Although these descriptions of the risk assumed by the company under the common or "commercial" accident-and-health-insurance policies are based upon forms actually offered, the reader is warned that many limited forms are on the market and that he should not expect such broad coverage in all cases. The exact extent of the risk assumed under any such policy can be determined only by a careful reading of the policy itself. State laws usually require a brief description at the head and on the filing back of all policies, but these cannot be relied upon to give an exact understanding of the risks covered. Much difficulty has arisen through popular misunderstanding of forms and the failure to realize the limited scope of policies purchased. Far more complaints to the state authorities concern claims under accident-and-health policies than perhaps any other type of insurance, complaints generally arising from failure to realize the limited coverage granted under the policy. As examples of limited policies, one form may be noted which differs from the company's most comprehensive accident-and-health policy only by the insertion in the sickness-indemnity clause, after the words "period of such total disability," the words "beginning with the fifteenth day thereof." The policy provides all the accident indemnity of the former policy but gives indemnity for sickness disability only after the first 2 weeks of disability, whatever its duration. The company in this case has been very frank and honest, printing in large type at the head of the policy, "this policy does not cover the first 2 weeks of any period of sickness disability." All policies are not so plainly labeled. The same company issues another form of policy which insures

. . . against loss caused directly and exclusively by bodily injuries sustained, solely and independently of all other causes, through accidental means, as follows: (*a*) While operating, riding in, demonstrating, adjusting or cranking an automobile; (*b*) In consequence of the explosion or burning of an automobile; (*c*) In consequence of suffocation by carbon monoxide gas from the exhaust of an automobile; (*d*) In consequence of being struck, run down or run over by an automobile while walking on or across any public highway.

The company properly notes in large type and red ink at the head of this policy, "This policy is limited to automobile accidents only," which should make clear to any purchaser the limited character of his policy. But the writer has seen forms as closely or more closely limited whose labels conveyed no such clear warning.

A particularly confusing type of limited policy is that offered in connection with newspaper subscriptions. The publicity describing it is usually couched in such general terms as to lead the reader to believe that it furnishes reasonably complete coverage, though a comparsion of the premium charged with those quoted on standard policies should rouse some suspicion as to its probable incompleteness. This suspicion will be confirmed by an inspection of the policy. The restriction of the coverage compensates for the cheap rate.

The statutes of the states that have adopted the standard-provisions law require that policy forms be approved by the insurance commissioner, but he cannot prohibit the issuance of a limited policy if it complies with the law, though he may and usually does endeavor to see that it is properly labeled.

Statutory Standard Provisions.—The third group of essential policy provisions in the standard analysis adopted for this book is that relating to procedure for loss settlement. The statutory *standard provisions* having arisen out of the discovery of abuse in loss settlement, it is natural they should pertain primarily to this subject. There are 15 such provisions required, and the use of 5 others is optional. The form prescribed for several of them is quoted in the statute in three different ways, one each for use in accident policies, in health policies, and in combined accident-and-health policies. The provisions are set forth in the statute in the precise form and wording in which they must

appear. In the following summary the sense only of the provisions is stated in condensed form. The following are the required provisions with brief comments on their origin:

1. That the policy and its endorsements and attached papers constitute the entire contract. The company may use a form which provides for prorating the claim in accordance with the company's published manual of rates and classifications if the insured is injured after changing his occupation to a more hazardous occupation or while doing any act or thing pertaining to any such occupation. It is, however, distinctly provided that accidents due to recreation or ordinary duties about the insured's home are not to be regarded as due to a more hazardous occupation.

An adjustment of this kind is proper where the hazard has been really increased, but recreational and home-duty hazards are part of the ordinary risk under the policy. Abuse in prorating such claims by some unscrupulous claim men, dealing with ignorant claimants, was the cause of this requirement.

2. That no statement of the insured not included in the policy and attached documents may be used to avoid the policy. Alteration of the contract by agents is prohibited, such alterations being valid only when approved in writing by an executive officer.[1]

3. That acceptance of a premium by an authorized agent reinstates a lapsed policy from the date of acceptance.

This is of particular importance in the case of annual policies with premiums payable in instalments. Prior to the requirement of this provision, some policies were issued providing that reinstatement did not take place until the payment reached the head office, placing on the insured the burden of delay or neglect of the company's agent.

4. That written notice of an accidental injury must be given within 20 days of its occurrence, and of disability from sickness within 10 days of its commencement.

The company is entitled to reasonably prompt notice to permit a proper investigation of the validity of the claim.

[1] Some states also provide in another section of the law that, in the absence of fraud, all statements purporting to be made by the insured are to be construed as representations and not as warranties.

5. That such notice, given on behalf of the insured or beneficiary to the company at a designated office, or to any authorized agent with particulars sufficient to indentify the insured, is sufficient notice, and that failure to give the notice within the time limits set shall not invalidate the claim, if it is shown to have been impossible to do so, and that notice was given as soon as reasonably possible.

6. That the company shall, upon receipt of the notice, furnish blanks for making full claim and, failing to do so for 15 days, the insured will be deemed to have complied with the requirements of the policy on submitting his own written proofs of claim within the time limit set in the policy.

7. That affirmative proof of loss must be filed within 90 days after the loss, or after the termination of the period of disability for which the company is liable.

8. That the company shall have the right and opportunity to examine the person of the insured at all reasonable times during the pendency of the claim and, unless prohibited by law, to make an autopsy in the case of death.

9. That all indemnities other than on account of disability will be paid within a named interval after receipt of due proof.

10. That accrued indemnity for disability (subject to due proof of loss) shall be paid at specified intervals during the continuance of the disability, and the balance, if any, at the termination of disability, immediately on receipt of due proof.

11. That indemnity for loss of life of the insured is payable to the beneficiary if living, otherwise to the insured's estate, any other indemnity being payable to the insured.

12. That, if the insured changes his occupation to one classified by the company as less hazardous than that named in the policy, the company will, on request, cancel the policy and refund the unearned premium.

The statute does not specify the basis of determining the unearned premium, but the absence of any reference to a short-rate table leaves the implication that it shall be pro rata. This is but a reasonable correlative of the right of the company to prorate claims if the insured changes to a more hazardous occupation.

13. That the consent of the beneficiary is not requisite to any

surrender, assignment, change of beneficiary, or other change in the policy.

If there were not such a provision, doubts as to the legality of such transactions might arise, since the beneficiary's interest in such a policy is considered a "vested" interest, though, even without such a provision, not always indefeasible. In some jurisdictions the latter proposition is not always admitted. Hence, the defeasibility is definitely provided for in the contract.

14. That legal action to enforce a claim may not be brought within 60 days after proof of loss has been filed, nor after more than 2 years after the expiration of the time within which proof must be filed.

The former limitation is necessary to give the company a reasonable time to examine the proofs and, if the case appears suspicious, to make adequate investigation. The latter is desirable to enable the company to know that at some time it can definitely close its files and drop a case. Fairly proving the facts on either side after such a lapse of time would be difficult, if not impossible.

15. That the time limits of the state in which the insured resides shall be substituted for those in the policy if the former are more liberal.

The following provisions need not be inserted in the policy, but if they are, the statute specifies the language of the provision. In their absence the company waives the right or limitation expressed. The insurer may use such of these provisions as it chooses. These are called in the statutes *optional standard provisions:*

1. Cancellation by the company. If the right is reserved to the company to cancel at will, it must do so by written notice delivered to the insured or mailed to his last address as shown by the records of the company, together with cash or the insurer's check for the unearned premium, pro rata. Cancellation is without prejudice to a claim originating prior to such notice. No specified number of days' notice is required, as under the fire and some other policies.

2. Contribution of several policies. There is no provision for apportioning a loss between several companies unless the insured failed to disclose to one or more the existence of the other insur-

ance. In that case the company from which the insurance was concealed may prorate the claim and pay that proportion of it which the insurance under its policy bears to the total insurance. But in that case it must refund the excess portion of the premium it received.

3. Limitation of benefits. Each company sets limits to the liability it is willing to assume on an individual risk of any class, and it usually takes precautions in issuing its policies to keep within those limits, looking up any other policies that it may have outstanding on the risk. But some companies wish to specify in their policies the maximum limit they will cover on the risk as a safeguard against the error of a clerk or agent. This they are permitted to do but the provision covering it must specify that all premiums paid for the excess insurance will be refunded.

4. Offsetting claims. If the insurer wishes to reserve the right to deduct from any claim the amount of any premium due and unpaid, or any unpaid note or order given for a premium, it must provide for it in the language specified in the law.

5. Age limits. Most companies decline to accept risks on persons under a certain minimum age or over a certain maximum. This they may specify in the policy, but again the provision must guarantee the refund of the premium paid for insurance that extends beyond those ages.

Industrial Policies.—A large volume of business is done among railroad and other industrial employees on a monthly-premium or installment-premium basis. Often the premiums are paid by an order on the paymaster of the employing road or corporation. These policies are lower in price than most policies offered the mercantile and professional classes, and correspondingly more limited in scope and benefits. There is also a large industrial business done among the poorer classes in the South, particularly Negroes. These limitations, in view of the less-educated class concerned, are causes of much misunderstanding, the prescription of the standard provisions only partly relieving the situation.

Noncancelable Policies.—The policies heretofore considered have been yearly-term policies, with no clause giving the insured the right to continue beyond the original term, and usually reserving to the company the right to cancel during the contract term. The latter right is not often exercised but, usually, when a

risk under an accident or health policy becomes in any way impaired, the company declines to renew. This leaves the former insured without protection, when his need is most acute.

This situation has led to a demand for a form of accident-and-health-insurance policy under which the company does not reserve the right of cancellation and the insured is guaranteed the right of renewal until the close of the normal period of active business life at age sixty or sixty-five. This demand has been met by some of the companies, principally those doing a life-insurance business as well as accident-and-health insurance.

In addition to the lack of cancellation clause and the fixed right of renewal, such policies are characterized by the absence, in most cases, of the death and specific indemnity benefits, the important benefit being the weekly indemnity for disability which, in the earlier forms, was payable for life if the total disability lasted so long. Since the number of disabilities of short duration are vastly more numerous than those of more serious character, the cost can be greatly reduced if these are excluded from the coverage, and still more so if the early part of any disability is not subject to indemnity. As most persons can finance themselves over such a period, the *noncancelable* policies are usually offered with a *waiting period*. The most popular waiting period is 90 days.

Noncancelable disability policies with a fixed rate of benefit for loss of time have been looked upon skeptically by many underwriters as likely to create a moral hazard since, if the insured's earning power declines, he may be able to collect more for his loss of time than he could earn at his business. He may resist the temptation to self-disablement, but the incentive to recovery from any disablement is certainly weakened. Experience, particularly during the recent depression, has confirmed this fear. The companies have sustained severe losses. Many have abandoned this type of coverage. Nearly all the others have carefully revised the forms. The tendency has been to reduce the age to which renewal is permissible, to eliminate or greatly restrict the provision for partial disability, and to give the policy more the nature of an indemnity contract by the use of a prorating clause, reducing the indemnity if the total insurance carried by the insured provides more than a fixed percentage

(usually 100 per cent) of his average earnings during a specified period preceding his disablement. Most of the companies still writing such policies have, furthermore, abandoned the provision for continuing payment of the loss-of-time benefit for the remainder of life and have limited the period to a fixed term of years or limited the aggregate amount that may be claimed.

Some companies issue a disability policy that does not contain a clause giving the company the right to cancel on giving notice in a prescribed form, though the company gives the insured no right of renewal and, indeed, reserves the right to refuse to renew. Such contracts are frequently designated as "noncancelable." Since the contract is for a year's term and the company cannot cancel within that term, perhaps some defense may be made for this labeling. The defense, however, at best appears to be based on a hair-splitting technicality. The designation may well mislead the buyer to believe that he has a policy that he may renew at will. It is difficult to believe that the deception is not intended.

Group Insurance.—In the development of the interest of employers in the welfare of their workers, there has grown up a field for group accident-and-health insurance of the employees of a single employer. This insurance is written under a master policy, which constitutes a contract with the employer, who pays the premium, certificates being given to the individual employees. As in the case of the noncancelable policy, the important benefit is the disability benefit covering nonoccupational accidents[1] and sickness disability. The standard provisions are not required, and an effort is made to simplify the contract as much as possible. Its most important provisions are those specifying the premium basis and method of payment, identifying the persons covered, and defining the disabilities for which indemnity is furnished.

Hospitalization Insurance.—Workmen's compensation laws[2] require that the injured employee be furnished medical and hospital care, which casualty-insurance carriers writing this insurance provide, making their own arrangements with doctors and hospitals. It is a natural step from this to group and even individual insurance furnishing medical and hospital service in case

[1] For treatment of occupational accidents, see Chap. XIII.

[2] See Chap. XIII.

of accident or sickness. One or two companies undertook it. There were also some not very reputable companies organized especially for this purpose. In a test case taken to the United States Supreme Court it was held that, when the company attempted to provide the medical service rather than merely paying the cost, it was practicing medicine which, in most if not all states, is in violation of law.[1] Since this decision the carriers have generally confined their medical and hospitalization coverage to provision for expense reimbursement. A number of carriers, however, offer policies agreeing to provide necessary hospitalization. The policies are similar in their general terms to other disability-insurance contracts. They vary in the type and duration of accommodation offered and the extent of the associated X-ray, laboratory tests, and similar services offered, the premium varying correspondingly.

Blue Cross.—Beginning early in the thirties some hospitals offered hospital care on a monthly prepayment (essentially insurance) basis. As this proved popular, groups of hospitals in the same community tended to offer the service. As the movement grew, the American Hospital Association took cognizance of it and set up in 1937 a Commission on Hospital service through which it has set up standards for nonprofit hospital service plans and recommended and sponsered laws providing for them. Those plans conforming to its standards are authorized to use as their emblem a blue cross with the seal of the American Hospital Association in its center. The plans are operated by nonprofit corporations organized in accordance with the law of the state of domicile. There are now nearly 90 such corporations extending across the country and covering about 19 million persons.

Each corporation is legally and financially independent, but they are closely allied and have perfected interrelations so that they may provide for their members when traveling. Although they issue group contracts mainly, some offer individual contracts also. The group contracts are negotiated through the employer who may pay part of the cost and in any event collects

[1] *Pacific Health Corp. v. California ex rel State Medical Examiners*, 306 U. S. 633 (1938) *per curiam* denial of appeal from decision of California Supreme Court [12 Cal. (2nd) 156 (1938)].

the employees' premiums through pay-roll deduction, remitting to the corporation in monthly totals. Both under group and individual contracts, hospital benefits may be provided for the spouse and minor children of the individual insured. The contracts are rather simply expressed and specify the type of accommodations (usually small-ward service) provided and the number of days for which they are furnished. Usually, if a longer stay is necessary, there is provision for a reduction from the standard rate charged the public for similar accommodations. There are some exclusions, *e.g.*, injuries covered under workmen's compensation laws, contagious cases, which usually must be placed in quarantine, hospitalization covering operations for conditions existing at the date of insurance, etc. The contracts vary somewhat between the different associations.[1]

The corporation makes contracts with the hospitals that it approves in its locality, and the insured has his choice among them. Since an epidemic or a disaster might so crowd the hospitals that accommodations could not be procured, the insurance contract excuses the association in that event and provides for refund premium. The system is so young that it is still in the development stage, and it is probable the contracts will not reach a set standard form for several years. Some of the associations have experienced considerable adverse selection in writing individual contracts; hence, the specialization on group coverage. As ways may be found to avoid the adverse selection, individual contracts may again be more freely offered. The system seems to occupy somewhat intermediate ground between commercial private insurance and social insurance.[2]

SUMMARY

1. There are four principal types of accident-and-health policies:

   a. Commercial.
   b. Noncancelable.
   c. Group.
   d. Hospitalization.

[1] The corporation is usually designated as an association, but the titles vary.

[2] See Chap. XXIX.

2. The largest volume of business is written under the group and group hospitalization forms.

3. Commercial accident-and-health policies are usually issued for annual terms and are cancelable at the option of the insurer.

4. Commercial accident-and-health policies are not standardized, and there is on the market a great variety of forms with varying coverage and limitations.

5. The laws of most of the states prescribe provisions for use in such policies, and usually require approval of forms by the insurance commissioner before they may be used.

6. Notwithstanding the precautions taken, there is much misunderstanding of these contracts by the insured, and no little friction in loss adjustment.

7. Noncancelable accident-and-health policies are intended primarily to furnish indemnity, in the form of income, for disability protracted beyond the term for which the disabled can usually finance himself, and are subject to a waiting period. They do not usually contain elaborate benefit schedules.

8. Group accident-and-health insurance contracts are negotiated between the insurer and an employer for the benefit of his employees. They usually provide only disability indemnity and define disability in simple terms.

9. Hospitalization contracts provide for hospital services for sickness and accidental injury not covered by a workmen's compensation law. They may cover all members of a family.

10. The largest volume of hospitalization insurance is furnished by nonprofit corporations affiliated with the American Hospital Association, known as "Blue Cross" associations.

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CHAPTER XII

LIABILITY-INSURANCE CONTRACTS

All the insurance contracts heretofore considered have covered the possibility of loss due to physical risk to which either the insured's person or property is exposed. Liability-insurance policies do not cover such a risk but cover a risk of financial loss due to occurrence of damage, actual or alleged, to the person or property of someone other than the insured, for which the insured is, or is claimed to be, legally liable to respond in damages. The liability insurances, together with the closely associated coverage of workmen's compensation,[1] are therefore frequently called "third-party insurance." The most important of the liability-insurance lines is that covering the liability of automobile operators and owners. But this is not the only line of insurance associated with the automobile. And the automobile has become so important a part of our present-day life that it has seemed best to include a special chapter on automobile insurance.[2]

Fundamentals of the Law of Negligence.—Since the need for liability insurance arises out of the responsibility of individuals for injuries to others, it is desirable briefly to note the fundamentals of the law under which such liability arises. The law of negligence is a branch of the common law and consists of a set of rules for determining the legal liability of one person for injuries unintentionally caused to another through the neglect of some care or duty. It rests on the old principle that each person must so conduct his affairs that another is not caused to suffer unjustly. Negligence in its legal meaning consists in

1. A legal duty to use care.
2. A failure to exercise such care.
3. The lack of distinct intention to produce the precise damage, if any, which actually follows.[3]

[1] See Chap. XIII.

[2] The special characteristics of automobile-liability-insurance contracts will be discussed in Chap. XV.

[3] SHEARMAN and REDFIELD on the law of negligence, §3.

With this negligence, in order to sustain a civil action, there must concur

1. Damage to the plaintiff.

2. A natural and continuous sequence, uninterruptedly connecting the breach of duty with the damage, as cause and effect.[1]

The plaintiff in such an action must himself be free from any negligence that may have contributed to the injury, the slightest degree of contributory negligence defeating his claim.[2] On the other hand, a person is responsible not alone for his own acts, but also for the acts of his employees and servants that occur during, and arise out of, their employment. This is particularly true where direction of their manner and method of work is exercised. Where such direction is not retained, but a contract is made for certain work to be performed by the contractor in such manner as he may deem best, his negligence will not ordinarily be imputed to the person for whom he performs the work but, should he fail to meet a claim for damages, the claim may, on various theories, be presented against the beneficiary of his contract. Even though there may be no legal liability, defense of such a claim is necessary.

It should be emphasized that one is not responsible for all injuries inflicted by instrumentalities under one's general control. Proof of legal negligence is essential. A person is not responsible for pure accidents, *i.e.*, Acts of God, like a stroke of lightning, nor for the consequences of action in emergencies where there is not time to decide a better course. The above brief statement is a summary of the law of negligence as it operates between strangers. As between employer and employee this law has been considerably modified and made less favorable to the employee.

Employers' Liability.—A line of precedents was established, beginning about one hundred years ago, abrogating the principle of agency just cited (the responsibility of a person for the consequences of acts of his employees) in its application to claims of

[1] *Ibid.*, §5.

[2] In some jurisdictions this harsh doctrine has been modified to one of comparative negligence under which contributory negligence does not defeat the claim but is to be considered by the jury in fixing damages. Even in the jurisdictions where the doctrine of contributory negligence has not been changed there is an increasing tendency to overlook very slight negligence on the part of the injured if the negligence of the other party is great.

employees for injury due to acts of fellow servants (employees). On the ground that employees generally know their fellow servants better than the master knows his workers and could and should decline to work with careless fellow workers, it was held that it was unfair and unjust to charge the master with responsibility for injuries done by fellow servants. The injured should present his claim against his fellow servant. This was the *fellow-servant rule* and was followed even when the fellow servant was a foreman, though later a counterdoctrine of *superior servant* was developed to hold the master liable when the injury was caused by the act of one in the latter class.

In England and most, if not all, of the states statutory *employers' liability laws* were passed, in general requiring the employer to provide safe conditions of work, but these were in considerable part nullified, first by low standards of reasonableness in considering whether the conditions were reasonably safe and, second, by the judicial doctrine of *assumption of risk*. This doctrine held that the employee, in consideration of the desire for employment, rate of wages, or other interest, assumed the obvious risk of his employment. Under this doctrine employees were in some cases denied damages even when working conditions were in violation of specific safety statutes if the condition causing was obvious and not hidden; *e.g.*, in one case where the machine was not equipped, as the law required, with a means of shifting the driving belt to an idling pulley to stop the machine for cleaning.

These doctrines, with the harsh doctrine of *contributory negligence*, gave the injured employee a very limited chance to enforce a claim against his employer. Happily the law of negligence has now been replaced as to most employments by the more modern principle of workmen's compensation[1] but, to those employees not covered by workmen's compensation laws, the law of employers' liability still applies though often with liberalizing modifications.

Liability Insurance Not Contrary to Public Policy.—On first consideration it would appear that such legal liability would tend to promote care and that the mitigation of its burden would be contrary to public policy as tending to reduce that care. This contention has been before the courts, but they have declined

[1] See Chap. XIII.

to press the rule of public policy so far. They have pointed out that these contracts do not absolve the negligent party from his direct liability to the injured, and that it is no concern of the public what collateral contracts for indemnity may have been made. This view has been taken in a long line of decisions without dissent.[1] It has also been held that there is a proper insurable interest to sustain such a contract,[2] and of this there is little room for doubt.

Development of Liability Insurance.—Liability insurance is a relatively new line. Beginning in England in 1880, it was at first confined to the coverage of liability of employers for injuries to their workers—*employers' liability insurance.* For many years only this form of liability insurance was written, but gradually manufacturers and other business people began to realize the need of protection against their liability to the public arising out of their various operations, which exposed the public to risk of injury. With the development of industry, this type of coverage has been in increasing demand, and an expanding line of policy forms has been developed to meet it. The modern tendency is to relieve the insured of worry and risk by consolidating the coverages under one form, so far as possible. There are, however, at present in use the following 13 types of direct liability coverages, and 3 types of contingent coverages which cover the possible liability in cases where another is likely to be primarily liable:

Direct Liability Coverages:

1. *Manufacturers' Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to manufacturers of every description.

2. *Contractors' Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to general contractors, building contractors, telegraph and telephone, electric light and power, and mining companies, and to other persons, firms, or corporations conducting operations which are not confined to manufacturing premises.

3. *Owners', Landlords', and Tenants' Bodily-injury-liability and Property-damage-liability Insurance (Also known as "General Public-liability and Property-damage-liability Insurance").*—Issued to owners or lessees of premises which are not used for manufacturing purposes, such as stores, office buildings, hospitals, restaurants, hotels, schools, and certain places of amusement and public resort.

[1] See VANCE, W. R., "Handbook of the Law of Insurance," p. 605.

[2] *Ibid.*, p. 605.

4. *Teams' Bodily-injury-liability and Property-damage-liability Insurance.* Issued to those who maintain, use, and operate bicycles, hand trucks, push-carts, draught animals and vehicles, as, for example, laundry and towel supply companies, lumber dealers, newspaper delivery companies, and truckmen.

5. *Elevator Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to those who maintain, use, and operate hoisting devices such as passenger and freight elevators and escalators.

6. *Theater Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to owners and lessees of places of amusement, such as theaters, motion-picture houses, opera houses, airdromes, halls or auditoriums used for theatricals, concerts, or for the showing of motion pictures.

7. *Sports Public Bodily-injury and Property-damage-liability Insurance.*—Issued to sportsmen of all kinds, such as baseball, basketball, football, hockey, polo, and tennis players. Special forms are available for golfers.

8. *Residence and Farm Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to owners and lessees of residences, farms, and private estates.

9. *Comprehensive Personal-liability Insurance.*—Issued to individuals and covering the insured and members of his family residing with him with respect to premises, not used for business, and personal activities other than motoring and some similar activities, *e.g.*, use of water craft of certain size—a somewhat broadened combination of 7 and 8 above.

10. *Comprehensive General-liability Insurance.*—Issued to business enterprises. Includes as required coverages:[1] owners', landlords', and tenants', elevator, manufacturers' and contractors', owners' and contractors' protective,[2] teams, and comprehensive[3] bodily-injury liability. Optionally it may include contractual and product liability, and property-damage liability for all conditions for which bodily injury is covered.

11. *Product Public Bodily-injury and Property-damage-liability Insurance.* Issued to manufacturers and distributors of commodities of various kinds, such as bakestuffs, canned goods, chewing gum, drugs, and gasoline.

12. *Druggists', Physicians', Surgeons', Dentists', and Hospital Bodily-injury-liability Insurance.*—Issued to professionel men, such as physicians, surgeons, and druggists, and to owners and lessees of drugstores and hospitals. Because of the nature of the obligation insured, no provision is made for property-damage liability insurance.

13. *Contractual Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to persons who assume the liability of others by contract, as, for example, where a manufacturer guarantees to hold the railroad company harmless for accidents occurring on a spur track which has been placed

[1] Exclusion of one or more is permitted if special circumstances indicate it is proper to do so.

[2] See p. 218.

[3] Applies to undisclosed or newly arising hazards for which there would be no coverage under the specific forms noted.

on his property for his own convenience, or, where a contractor installing a signal system in a subway in which trains are moving assumes liability for all accidents to members of the public which may be attributed directly or indirectly to his operations, and in addition agrees not to hold the subway company responsible for any accidents to his own employees which may result from the operation of the subway.

Contingent Liability Coverage:

1. *Contractors' Protective Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to contractors to provide protection against the contingent liability resulting from claims for damages arising out of operations conducted by subcontractors.

2. *Owners' Protective Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to owners of buildings in the course of construction to provide for the contingent liability resulting from claims for damages arising out of operations conducted by independent contractors and their subcontractors.

3. *Landlords' Protective Bodily-injury-liability and Property-damage-liability Insurance.*—Issued to the owner or general lessee of a building who has leased the entire building to another, to provide for the contingent liability arising out of the maintenance, use, and operation of the building. This coverage is available only where the lessee of the building controls the elevators, operates the same, furnishes power, and has charge and control of the premises except for such repair and maintenance work as the policy-holder may be forced to undertake for the preservation of his property.

The several types of coverage, except the comprehensive forms, are mutually exclusive, though the indemnity offered is essentially the same. The differences are due to (1) differences in circumstances and probable causes of injuries or (2) differences in conditions relating to premium payment.

Liability policies are not standarized by statute nor are they subject to approval of state authorities, but as the result of evolution under competitive conditions they have become largely uniform and standardized.

It will not be necessary to examine in detail each of these forms. The *comprehensive general-liability policy* may serve as a type for study.

Declarations.—A written application is not usually required for liability insurance, but there is attached to the policy a schedule of *declarations* which, by the acceptance of the policy, is made a part thereof. These declarations are prepared from data submitted by the insured or his representative and identify the insured, the location where his work is carried on, its extent

and character, and other important facts bearing on the risk. They are not designated as warranties, and their status will, therefore, be that of representations.[1] Under the modern relaxation of the doctrine of warranties in most branches of insurance, there would probably be little practical difference, if they were designated as warranties.

Parties to the Contract.—The parties to the contract are the insurance carrier and the named insured, but if the named insured is a partnership, the individual liability of each partner is covered while he is acting within the scope of his duties as such, in connection with the business operations of the partnership; if the named insured is a corporation, any director, executive officer, or stockholder is also covered while acting within the scope of his duties as such. The persons whose injuries form the basis of the contract are, in general, in no way parties to the contract and are not bound by its terms, as are the beneficiaries under a life- or accident-insurance contract. The contract is solely a contract for the benefit of the insured and for his indemnification when subject to the loss covered by policy. The injured person has no direct right of action against the company. The policy does provide that any person (or his legal representative) who has secured a judgment against the insured or a written agreement with the insured and the carrier for payment shall be entitled to recover under the terms of the policy in the same manner and to the same extent as the insured. But it contains a further provision, "Nothing contained in this policy shall give any person or organization any right to join the Company as a codefendant in any action against the Insured to determine the Insured's liability."[2] If the insured became bankrupt and therefore paid nothing the carrier under a strict contract of indemnity for the insured would not sustain any liability. The policy provides, "Bankruptcy or insolvency of the Insured or the Insured's estate shall not relieve the company of any of its obligations hereunder." This does not, in general, give the injured the right to prosecute his claim against the com-

[1] See p. 56.

[2] The reason for this provision is the tendency of a jury to enhance the amount of the verdict when it knows that an insurance company rather than the individual defendant will pay the award.

pany except as it may be given by the general provision noted above. In some states the statutes require that in event of bankruptcy of an insured under a liability policy, holders of final judgments for liability covered by the policy shall be entitled to make claim against the carrier. Editions of the policy for use in such states contain a provision to that effect.

Risk Transferred.—The insurance carrier obligates itself to do four things in behalf of the insured which, stated in order of their occurrence, rather than the order stated in the policy, are

1. To pay for such immediate surgical relief as is imperative at the time of the accident.[1]

Common decency and sometimes also statutory provisions require the uninjured party at the time of the accident to see that the injured receives suitable first aid, and the furnishing of this is not considered an assumption of responsibility. More elaborate care might be so construed, and for this the company furnishes no indemnity. Indeed, if the insured does so assume responsibility he forfeits his rights under the policy with respect to that accident.

2. To investigate cases of death or bodily injury covered under the policy, to negotiate for settlement of claims on account of such cases, and to defend suits even though groundless.

3. To pay on behalf of the insured all sums[2] which the insured shall become obligated to pay by reason of the liability imposed on him by law or assumed by him under contract,[3] for damages, including damages for care and loss of service, because of bodily injury, sickness, or disease, including death at any time resulting therefrom, sustained by any person or persons and caused by accident.[4] If the policy covers property-damage as well as bodily-injury liability, there is an additional promisory clause

[1] Provision may be made for further care under the *medical-payments* clause, similar to that contained in automobile policies. See p. 268.

[2] Up to the limits set in the policy.

[3] If contractual liability is covered under the policy and as defined therein.

[4] By reason of the phrase "caused by accident" some claims arising from rendering or omission of professional service might not be covered. A supplementary endorsement would be necessary to cover the *professional* liability.

By another provision of the policy, assault and battery, unless committed by or at the direction of the insured, is deemed to be an accident.

identical with the above but substituting for the words "bodily injury, sickness, or disease" the words "damage to property."

4. To pay, in addition to the damages, all expenses of investigation and settlement, including costs assessed against the insured, premiums on bonds for release of attachment and on appeals in any defended suit, and interest on that part of any judgment that is not in excess of the limits set up in the policy.

By this promise the risk of having to meet these expenses is transferred from the insured to the company. Independent of the saving in substituting the certainty of a fixed and relatively small premium for the possibility of heavy losses, the insured gains because the company is a specialist in such matters, and can usually act more economically than the insured.

Not all accidents for which the insured may be liable to respond in damages are within the scope of the policy, but only those specified in the policy. These specifications include a positive description of the class of accidents to be covered, and qualifying exceptions. It is at this point that the major differences between the various forms of liability policies are found. The types of operations covered by the comprehensive general-liability policy are stated in the declarations or application.[1] The policy lists exclusions as to bodily injury as follows:[2]

1. Contractual liability not defined or set forth in the policy or endorsements.
2. Liability for workmen's compensation benefits, except those assumed indirectly under a covered contractual liability.
3. Liability for injuries due to ownership, maintenance, or use, including loading and unloading, of
    a. Watercraft while away from the premises of the named insured.
    b. Automobiles while away from such premises or the ways immediately adjoining.
    c. Aircraft.

From the property-damage-liability covered there are excluded

1. Property owned, occupied, or used by, or rented to, the insured.
2. Property in the care, custody, or control of the insured, except as to contractual liability covered under the policy.

[1] In the form used on the Pacific coast the declarations merely indicate the limits for the bodily-injury cover and whether or not automobile property damage is covered, but an application and risk analysis is used in addition.

[2] These are summarized, not stated in detail as in the policy.

3. Any goods or products manufactured, sold, or distributed on the premises.
4. Damage by water from sources of loss that may be covered by a water-damage- or sprinkler-leakage-legal-liability policy.[1]

Amount of Insurance.—The bodily-injury liability under the policy is limited to a maximum amount for the claim of any one person, and to a larger amount for any one accident, no matter how many persons may be involved. This is true of all bodily-injury-liability policies. The *standard limits* on which rates are quoted are $5,000 and $10,000, respectively (usually referred to as 5/10 limits), but these may both be increased on payment of an increased premium. These limits refer to the amount payable to the claimants and do not include the amount the carrier has to pay for surgical aid or expenses. There is also a maximum limit set per accident for property-damage liability. In the comprehensive policy, there may also be an aggregate limit on each section for bodily injury and property damage separately.

Existing Insurance.—The comprehensive policy is of recent introduction, and frequently when it is taken out there are existing policies covering some of the hazards included in it. If these are in the same carrier, they are usually canceled pro rata. If they are in other carriers, the comprehensive policy may be endorsed to exclude these hazards until the expiration dates of the several specific policies. If neither of these actions is taken, there might be overlapping coverage. To avoid this the policy provides that the insurance under it as respects such hazards shall be excess cover, *i.e.*, the carrier shall not be liable except for the excess, if any, of the claim over the limit of the specific policy.

Position of the Insured.—In order to assure that the carrier will not be used by its policyholder as a means of cheaply establishing a reputation for liberality, the insured is forbidden to assume voluntarily any liability or to incur any expense except for imperatively needed immediate surgical aid, or to settle any case except at his own cost. He may not interfere in the conduct of any case and must aid the company, at its expense, as requested in procuring evidence, witnesses, and conducting the case, which is done in the assured's name.

[1] This exclusion may be removed, as to property not in the care and custody of the insured, by an endorsement.

Despite these stringent provisions the carriers are sometimes the victims of collusion between the insured and the claimant. This is particularly true in cases where a guest passenger in an insured automobile is injured and brings suit against the host, which would not be done were he not insured. In one case known to the author, a mother took out guardianship papers over her daughter in order to sue the husband and father for damages on account of injuries sustained by the daughter while riding with him. The company was able to show the collusion in this case and successfully to deny liability. Whether it should be possible to procure insurance that would indemnify the injured in such a case is beside the point here, which is that the policy is intended to indemnify the insured only for the cost of liability under the law for damages arising out of his accidents.

Although, as indicated, the insured is forbidden under penalty of voidance of his policy to assume any liability, in the confusion attending an accident he frequently does so directly or by implication. This is particularly true in connection with automobile accidents. The carriers recognize this frailty of human nature and frequently waive the voidance when they have no reason to suppose the act of the insured is in bad faith. The cautious policyholder should not rely upon the possible generosity of his insurer but carefully observe his obligation.

Cases have arisen where the plaintiff has offered to settle for less than the policy limit, but the carrier, confident in its defense, has refused his offer. Later the case has been lost and the judgment has exceeded the policy limit. It might seem unjust for the carrier to be required to pay the insured only that limit and leave him to bear the excess since he could have settled for the lesser amount, perhaps less than the excess, but under the policy terms he could not do so and claim reimbursement from his insurer, for that would be interference with the conduct of the case. The courts have generally held in such cases that the carrier may compel the insured to accept payment of the policy limit as the fulfillment of its obligation, if the carrier's refusal of compromise was merely a mistake of judgment without evidence of negligence or bad faith.[1]

[1] *Olympia Fields Country Club v. Bankers Indemnity Insurance Co.* (Appellate Court of Illinois), 60 N.E. (2d) 896 (1945).

The clause requiring the insured to subrogate the carrier to any right he may have to recovery against other parties is found in this, as in policies covering against other risks. Such a clause is practically always necessary in order that the policy may be a contract of indemnity and not a source of profit.

In the same category is the clause providing that, if there is other insurance covering the same risk, the loss shall be borne pro rata.[1] Of course, the rule of marine insurance that the first dated policy be first exhausted might be applied and avoid double recovery, but this prorata provision seems much fairer.

Procedure in Loss Settlement.—In view of the nature of the subject matter of the insurance, it is not necessary for the policy to specify, as in the fire-insurance policy, an elaborate and detailed procedure for loss settlement. There are, however, certain things which the insured must do to carry out his part of the contract. He must give notice as soon as practical of any accident, with sufficient particulars to indentify the injured. He must also give notice with full particulars of any claim that may be made upon him on account of such accident and must immediately forward every summons or other process served in connection with any suit that may be brought to enforce such a claim.

Assignment of Interest.—As the personal element is an important part of the hazard under this policy, no assignment of interest is binding upon the carrier unless consented to by the carrier.

Premium Computation.—The premium bases and rates for the hazards to which the policy applies are those applicable in accordance with the carrier's rules, rates, rating plans, premiums, and minimum premiums. The hazards, the rate base, and the rates are specified either in the declarations or in the application.

The policy is issued on the basis of a provisional premium, which may be revised if changes in insurance exposure arise during the policy term. The basis of premium for bodily-injury cover for manufacturing and contracting operations is the amount expended for pay roll during the policy period. This amount cannot be known in advance but is estimated for the purpose of fixing the provisional premium. Upon the termination of the policy or at the end of each annual period, the earned premium is

[1] But see p. 222 *in re* special cases under the comprehensive policy.

computed on the basis of the actual expenditures, and the premium is adjusted accordingly. The policy may be written for a 1-year or a 3-year term. The rates for 3-year policies on certain hazards are less than three times the annual rate. This is not true for covers for which the rate is based on pay roll.

Cancellation.—The policy is cancelable by either party on written notice stating when, not less than a fixed time (usually 5 days) later, cancellation is to be effective. If notice is mailed, the time of mailing is the effective time of notice. On cancellation, the actual pay-roll expenditure for the time covered by the policy is ascertained and, if the cancellation is at request of the company, settlement is made by applying to that amount the rates named in the declarations. If the cancellation is at the request of the insured, the adjustment is on the basis of a higher short-rate table quoted in the policy.

Notice of cancellation is to be served as may be required by law but, if no specific way is required, notice is to be mailed to the assured's address as set forth in the declarations.

Inspection.—As the condition of the insured's premises and the manner of conducting his operations are the essential factors determining the risk, the company is given the right at reasonable times to inspect them.

SUMMARY

1. Liability insurance covers the defense of claims and suits for damages arising out of injuries to the person or property of others sustained in accidents for which it is claimed the insured is liable, and the payment up to certain limits of damages awarded.
2. The policies generally provide two maximum limits: one for claim of one person and another for the total claims in a single accident.
3. Liability insurance is a third-party coverage, since it arises out of loss or damage to persons other than the insured.
4. The liability contract is one of indemnity to the insured only, but the insurer agrees to pay on his behalf damages for which he may become liable.
5. There are many types of liability policies covering different classes of operations, but in other respects they are essentially alike.

6. Defense is conducted in the insured's name, and he is bound to cooperate and assist.

7. There are the usual clauses providing for subrogation and for prorating losses under several policies when found on the same risk, and for cancellation.

8. The contract is personal and unassignable.

9. There have recently been developed comprehensive liability policies which cover broadly all bodily-injury liability of the insured and which may also cover his property-damage liability.

References

Kulp, C. A., "Casualty Insurance," rev. ed., Chaps. 4, 8, 10.
Sawyer, E. W., "Comprehensive Liability Insurance."

CHAPTER XIII

WORKMEN'S-COMPENSATION-INSURANCE CONTRACTS

At one time, if a workman was injured while in the employ of another, he was obliged to bear the economic cost of his injury as well as the physical suffering, unless he could prosecute a successful claim against his employer for damages on the ground that the employer's negligence was the cause of his injury. His opportunity to do so was much less than in the case of a total stranger, because of the peculiar development of the common law of negligence as applied to the relation of master and servant. Some relief was furnished by the passage of various statutory modifications of that law in the form of employers' liability laws, but the employee was still at a severe disadvantage.

Within the past 35 years all but one of the states of the United States have supplanted this method of dealing with work injuries by the system of workmen's compensation, though in most states there is a considerable proportion of workers whom the act does not cover. Most European countries preceded the United States in this reform. The story of the hardships of the old system and the battle for the reform is interesting and instructive but is not within the scope of this book. It is sufficient to indicate what is meant by the principle of workmen's compensation.[1]

Principle of Workmen's Compensation.—Very briefly stated, the principle of workmen's compensation is that the economic loss to workmen, owing to work accidents, is a part of the cost of production of the goods on which the work was being done, and, as such, should be borne by the consumers of those goods in the same manner as the destruction and obsolescence of the machinery so used is presumed to be, by being included in the cost of production. In order to do this, the cost is first to be

[1] For further discussion see, *inter alia*, C. W. Hobbs, "Workmen's Compensation Insurance"; R. H. Blanchard, "Liability and Compensation Insurance"; E. H. Downey, "Workmen's Compensation."

assessed on the employer who produces and controls the marketing of the goods. The practical application of this principle requires that the employer be made responsible for indemnity to the injured in all cases without the question of fault or negligence entering into the matter, though, in order not to remove from the employee all incentive to care, only partial indemnity is provided. This system has the added social advantage of removing a large cause of litigation, freeing the courts of work which was seriously clogging their calendars and which was conducted at great social cost.

It is inconceivable, even though the question of fault be removed from the case, that disputes will not arise. Of course, only real work injuries come within the scope of the principle, and it must be decided, in any case where it is not obvious, whether the injury for which indemnity is claimed is a real work injury.[1] The indemnity should correspond to the injury, and there must be some way of determining disputes as to the nature of the injury and its degree. At first this was sometimes left to the courts, but court procedure is so cumbersome that an administrative commission is usually set up with the power and duty to decide such cases by a brief, simple, and summary procedure.

Although it is perhaps not to be stated as a part of the *principle* of workmen's compensation, it has been found socially desirable to make the indemnities payable in installments as are wages, and to protect the employee against the possible insolvency of his employer while compensation payments are yet due, by requiring the employer to insure his liability in an authorized insurance carrier.

WORKMEN'S COMPENSATION LAWS

General Terms of State Compensation Laws.—The compensation laws of most states in the United States first define the employments subject to the law. This may be by enumeration of classes of industry, or by specifying that all except

[1] A typical legal definition is "personal injury in the course of, and arising out of his occupation"; in several laws the words "by accident" follow the words "personal injury." The latter phraseology excludes occupational disease.

certain named ones are subject. In no state are all occupations brought under the law, usually because of the political pressure of some employing classes. The most common exceptions are agricultural, domestic, and casual labor, or labor not in the course of the employer's business or occupation, or the employees of establishments not employing more than a specified number of persons.

Owing to constitutional objections that have been raised to compulsory compensation laws, the laws of some states are theoretically optional both as to employers and employees, failure to choose usually being regarded as election to be subject to the provisions of the compensation act. However, as a part of the workmen's compensation law, the employers' liability laws have been amended in such a way that either an employer or an employee who rejects the terms of the compensation law is at a serious disadvantage. In the optional laws this appears early in the act.

The act next provides a scale of indemnities for various types of injuries. There is great variety in the several laws in this respect, but all, or nearly all, conform to the following general scheme:

1. *Medical and Surgical Aid.*—The employer or his insurer is required to furnish such medical and surgical aid and attention including medicines, appliances, and hospitalization as are necessary to cure and relieve the injured, subject, in some states, to maximum limits of time and cost. The supervising commission is the judge of what is necessary.

2. *Waiting Period.*—In order to keep the cost down and discourage malingering over trivial injuries, there is usually a period of from 3 days to 2 weeks during which the injured receives no indemnity. This is known as a "waiting period." If the period of disability is protracted, indemnity is, under many laws, payable for this period. A waiting period of 1 week or 10 days, with a proviso that, if the disability continues beyond 7 weeks, indemnity shall be payable from the date of injury is not uncommon.

3. *Fatal Injury.*—The employer or his insurer must pay the expenses of last illness and burial, usually not to exceed a fixed maximum limit. In addition to this, a weekly indemnity is payable to dependents in accordance with the degree of depend-

ency. The rate of compensation and its duration vary greatly from state to state. The indemnity for total dependency is usually the same percentage of wages as for temporary total disability (explained below), and the duration varies from a life pension to widows, and to children up to age eighteen; to a period as short as 5 years. In some states, however, the indemnity is dependent on the number and relation of dependents, *e.g.*, 30 per cent of wages to widow and 10 per cent to each child up to a total limit of 66⅔ per cent of wages, with the proviso that, if there be no widow, 15 per cent is payable for each child. In cases of partial dependency, the rate of indemnity generally is proportional to the amount devoted by the injured to the dependents.

4. *Total Disability—Temporary.*—Subject to the exclusion of the waiting period, temporary disability is compensated for by a weekly indemnity of a percentage (usually 60 or 66⅔ per cent) of the weekly wage at the time of injury, but subject to maximum and minimum limits. The maximum limit varies considerably, corresponding to a wage of $30 to $40 per week, while the minimum corresponds to about a $10 wage in most states. In the case of very young persons, the prospect of increase may usually be taken into account by the commission in fixing compensation.

5. *Total Disability—Permanent.*—The rate of indemnity for permanent total disability is usually the same as for temporary disability. The limit of its duration ranges from a relatively short period, say 6 years, to life under the more liberal acts.

6. *Partial Disability—Temporary.*—For temporary partial disability, indemnity is usually provided at the same percentage of loss in earnings as is payable for total disability where the loss is the total wages.

7. *Partial Disability—Permanent.*—The most common cases of permanent partial disability are those due to dismemberment. Most laws contain a schedule of specific indemnities in lieu of all others (or in lieu of all other indemnity except that for total disability during the healing period), covering the most common types. These schedules provide indemnity at the rate for total disability for a number of weeks for each specified dismemberment, for example, under one such schedule, loss of sight

of one eye is compensated for by 75 weeks' indemnity. Loss of use of a member is usually to be treated as loss of a member. Various rules are provided for handling the cases not set down in the schedule, and in one state (California), the commission is given authority to frame and change, from time to time, a schedule that shall take into account the nature of the injury and the age and occupation of the injured.

8. *Disfigurement.*—In some states additional benefits are provided for such facial or other disfigurement as tends to handicap the injured in procuring employment.

9. *Occupational Disease.*—Under some laws, disability due to sickness contracted in the course of the employment and arising out of it is compensable; under others, it is not. If compensable, the indemnities are as for the same type of disability as that due to accident.

Industrial Commission.—There is usually provided a commission to administer the act, which may or may not have other duties, such as the administration of general labor laws. Provision is made for the functioning of the commission and for the supervision of claim payment. Sometimes, the statute provides for notice of injury to employer and commission. Sometimes, it is left for the commission to lay down the rules in this respect. The statute usually lays down the rule for determining the wages on which the indemnity in any particular case is to be based.

Insurance.—The employer is usually required to furnish evidence that he has insured against his liability under the act, or to meet such requirements as the commission prescribes for carrying his own risk. The commission is often given supervision over the provisions in policies covering such risks, and only forms approved by the commission may be used. In some states, the commission is also given supervision over the rates and other underwriting practices of such insurance. In others this is delegated to the insurance commissioner. In a few states there is no supervision of this sort.

In at least one state[1] the employer is released from his liability if he carries insurance even though his carrier becomes insolvent

[1] California, which requires each carrier writing workmen's compensation insurance to maintain a deposit with the state or furnish surety bonds to cover the amount of its unpaid losses computed on a severe standard.

and is unable to pay. In some other states insurance with the State Fund releases him but private insurance does not. In Arizona the State Fund must take over and pay the unpaid compensation liabilities of insolvent private carriers. The Industrial Commission of that state protects the Fund by requiring deposits or surety bonds from private carriers. In other states the employer must pay the compensation benefits due his employees if his carrier fails. It behooves an employer in such a state to see that his carrier is financially strong.

It is possible that the employer whose insurer becomes insolvent may also become insolvent. To avoid such contingencies New York, following the depression of the thirties, passed legislation requiring workmen's compensation insurers to pay stated percentages of their premiums into funds in the hands of state authorities to take over the workmen's compensation liabilities of insolvent carriers. There are separate funds for stock and mutual carriers.

The above is not an outline of the compensation law of any one state, nor does it pretend to be exhaustive. There is given only so much as is necessary to understand an explanation of the policy of insurance covering the workmen's compensation risk. The terms of compensation laws of most states are frequently amended,[1] and the reader is warned to seek the latest statute if desiring to study the precise law in any state. No attempt will be made here to analyze critically either any one law or compensation laws in general. This has already been ably done by others.[2]

THE CONTRACT

Development of the Universal Standard Form.—Variation and change in the benefit schedules of the several states of itself imposes difficulties on the insurance company doing business in many states. Variation in prescribed forms would add greatly to this, and variation in forms used in states where it is not necessary that an approved form be used would tend to create a competition in forms between companies, which might well be

[1] Proposals to amend are presented at practically every session of every state legislature, though the vast majority fail of passage.

[2] See Downey and others above cited.

made to obscure real differences in the merits of the competitors. For these reasons, certain company executives early started a movement for the development of a form which, with a minimum of change by endorsement, might be approved in all jurisdictions and used interchangeably. At first the goal seemed hopeless of achievement but, after much effort and conferences between committees representing insurance carriers and industrial commissions, such a form was worked out. It is known as the Universal Standard Workmen's Compensation and Employers' Liability Policy and is in general use throughout the United States.[1]

Consideration.—The contract is based on a schedule of declarations which appears on the third page of the policy and is made a part of it. A signed application is not usually taken. It should be noted that workmen's compensation insurance is *real* third-party insurance in the sense, not only that the event insured against must occur to a person other than the insured, but also that the insurance is for the benefit of that third party. The state is especially interested in the protection of the third party and will not permit an insurance contract in such a form that his interests may be jeopardized by the truth or falsity of the representation of the insured, his employer. Hence, these declarations are not made warranties. On the other hand, they serve as the basis of establishing and adjusting the premium for the policy, and identifying and underwriting of the risk.

Parties to the Contract.—Nominally, there are two parties to the contract: the company and the insured employer designated in the declarations. Actually, there are four parties interested in the contract; the two additional parties are the employees collectively, and the commission which, in some states, has the right of veto of cancellation of the contract and in all has important rights of supervision of the carrying out of its terms. The rights of the employees are directly enforceable against the company, either by the employees themselves or, where the law authorizes it, by the commission.

Risk Transferred.—The company takes over two kindred classes of risks to which the insured is subject: (1) the obligations

[1] Not used in Massachusetts, Colorado, or Arizona.

employed, the chance of a verdict in excess of the usual limit is remote, and it was deemed much better to give a full-coverage policy.

Claims under the employers' liability coverage are very rare occurrences.

Corresponding to the service of defending suits under the liability policy, the company takes over the investigation of accidents and all labor and expense attendant on the settlement of claims that may arise.

As indicated earlier[1] it was recognized that a state endorsement would probably be necessary to adapt the policy to local laws and commission rules. In the passage of time state endorsements have become lengthy and complex, but the standard policy serves as the base except in a few states.

Term.—The risk is taken over for a definite period beginning at 12:01 A.M. on a date stated and terminating at the same hour on a date stated. This hour was chosen as the one when most plants are idle, and it means that the coverage begins with the start of work on the day named and closes with the close of operations on the day preceding the expiration date. A compensation policy is never written for a period longer than one year.

Limitations.—Only two limitations on the coverage are stated:

1. If the employer carries other insurance covering a claim under the policy, he cannot recover more from the company than that proportion of any claim which the insurance under it bears to the total insurance.

2. In the event of a payment, the company is, to the extent of the payment, subrogated to any rights of the employer or any claimant against others claimed to be responsible.

The first provision is negligible in practice because it is not customary to issue concurrent policies of workmen's compensation insurance on the same risks. The confusion in loss settlements would be so great that the practice would be impracticable, no matter how large the risk might be.

The second provision was probably thought necessary to preserve the company's rights to subrogation, but most workmen's compensation laws contain specific provisions covering actions in the case of accidents for which it is claimed parties other than

[1] See p. 233.

the employer are responsible. Usually, the employee in such cases has the option of taking his indemnity under the compensation law and giving a subrogation assignment of his rights against the tort-feasor, or of proceeding directly against him. In the former case, if the company recovers more than the compensation paid, it must pay the excess received to the injured employee after deducting no more than reasonable costs.

Provisions Relating to Loss Settlement.—The compensation law, as indicated above, specifies the procedure by which an injured employee may establish his rights and, as the provisions of the compensation law are by the terms of the policy made an integral part of it, the procedure laid down in the law governs the settlement of losses under it. It is not necessary, therefore, for the policy to contain specific provisions for loss settlement as are required, for example, in the fire-insurance policy.

The policy does, however, require the employer, upon the occurrence of an accident, to give immediate written notice to the company with the fullest information obtainable. He must give like notice with full particulars of any claim made and forward any papers served on him in any suit. In this respect the policy resembles the liability-insurance policy and, doubtless, if he failed to give notice in a case of action at common law, or under an employers' liability act, his right to indemnity would be forfeited. But it would be quite contrary to the spirit and intent of the compensation laws so to permit an employer to deprive his employee of compensation.

Consequently, though the policy provides that nothing elsewhere contained in it shall relieve the employer of this duty, it is also provided that, as between the employee and the company, notice to, or knowledge of, the insured employer of an injury or death covered by the policy, shall be notice to or knowledge of the company. Further, it is provided that, for the purposes of the workmen's compensation act, jurisdiction over the employer shall be jurisdiction over the company (though its principal office may not be in that jurisdiction), and the company is bound by judgments, awards, decrees, orders, or decisions rendered against the employer insured in the form and manner provided by the workmen's compensation act.

Although the failure of the employer to perform his proper obli-

gations under the policy cannot affect the rights of the injured employees, if such failure were willful and serious, he would undoubtedly find his insurance canceled with considerable promptness unless he reformed. He would be liable to reimburse the insurer, though the author knows of no case where such a claim has been made.

Other Provisions.—As in the case of the liability policy, the precise risk assumed, or to be assumed, by the company cannot be told in advance, since it varies with the extent of the operations carried on. The measure of those operations is the pay-roll expenditure to which they give rise. This is estimated in advance, and the policy provides that the company shall have the right to examine and audit the books and records of the insured to determine the actual expenditure. Provision is made for adjustment by payment of the additional premium thereby indicated, if the actual pay roll exceeds the estimated, and for refund of the excess paid if the actual proves less than the estimated. In practice the estimated rarely, if ever, exceeds the actual.

Cancellation.—Subject to the restrictions, if any, in the workmen's compensation law on the rights of the insured or insurer to cancel existing insurance, the policy may be canceled by either party on written notice to the other stating when, not less than 10 days thereafter, the cancellation shall be effective. In event of cancellation, the pay roll must be audited as is provided for at the end of the policy term. If the cancellation is at the instance of the insurer, the adjustment is made by applying the rates named in the policy to the actual pay roll in each classification just as at expiration. But if the cancellation is at the instance of the insured, higher rates are applied to the pay roll corresponding to a short-rate table in the policy.

Inspection.—Since the physical condition in which the plant is kept, and the morale and discipline maintained among the employees, vitally affect accident rates and the cost of accidents under the policy, it is important to the insurer to know that proper attention is given to these items. Therefore, the policy provides that the insurer shall be permitted at all reasonable times to inspect the plants, works, machinery, and appliances covered by the policy.

Not only is it a privilege of the insurer to inspect but, by another clause, it is its duty, for it promises to serve the employer by inspection of the workplaces covered by the policy, and thereupon to suggest to the insured such changes and improvements as may operate to reduce the number of severity of accidents during work.

Since the carriers are desirous, both in their own interest and in that of the community, of reducing accidental imjuries to a minimum, they have developed skilled engineering departments specializing in accident prevention. An accident in a manufacturing plant usually does considerable damage beside the injury to the worker involved. Almost always, material is spoiled, and sometimes machinery is damaged. The staff, too, is more or less disturbed for some time after the occurrence with reduced output and increased spoilage as a further consequence. Thus financial as well as humanitarian motives press upon the employer to prevent accidents, and the guidance of these skilled specialists is a valuable aid of which the more progressive employers are glad to avail themselves. It is, therefore, not a mere euphemism for the carriers to refer to inspections as a service to the employer. This is especially true since, under merit-rating plans, the gains from reduction in accidents tend to be refunded through rate reductions granted for physical improvements or better experience.

Assignment.—Assignment of interest without the consent of the carrier is not permitted.[1] The insurance under the policy is not of workmen in a particular place, but of the insured in respect to his obligations under the workmen's compensation law. In this respect the contract is personal to the insured and, without the consent of the carrier, he cannot substitute another as insured.

Alteration.—The policy specifies that only certain officers of the carrier may waive or alter any condition or provision of the policy. It goes further and provides that neither notice to any agent nor knowledge possessed by any agent or other person shall be held to effect a waiver or change in any part of the contract.

[1] Because of merit-rating rules relative to change of interest, carriers rarely consent to assignment, preferring to cancel the policy pro rata and issue a new replacing policy.

But it does authorize the agent countersigning the policy to change the written part of the contract, the declarations, and these changes become binding on the carrier on being initialed by him.

SUMMARY

1. The carrier agrees to pay the employees of the insured the benefits to which they may be entitled under the workmen's compensation law.
2. The provisions of the workmen's compensation law take the place of the usual provisions for loss settlement.
3. The premium is based on a pay roll to be estimated in advance and later definitely determined on audit.
4. The policy provides for the carrier's assuming any residual statutory, or common-law, employers' liability.
5. It is provided throughout that, in event of any conflict between the terms of the policy and the provisions of the workmen's compensation law, the provision of the workmen's compensation law takes the place of the policy provision.

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CHAPTER XIV

FIDELITY AND SURETY BONDS

Companies issuing fidelity and surety bonds are classified under the insurance laws of most states as insurance companies. There are, however, excellent reasons for agreeing with bonding underwriters that, as to many types of bonds, the business of suretyship is not an insurance business. Before proceeding to a consideration of bonding forms it will, therefore, be well to consider briefly the history and development of the practice of suretyship and particularly of corporate suretyship.

Antiquity of Suretyship.—When one person undertakes an agreement of any sort (*e.g.*, gives his note for a sum due 3 months hence, or agrees to build a house, or even promises to restrain his temper and keep the peace), and someone else guarantees by endorsement or by some other binding engagement that he *will* do so, the second person is said to be a surety for the first. Suretyship is a very ancient practice. From the warnings against becoming surety for a stranger in the Proverbs of Solomon,[1] it may be inferred that voluntary suretyship was practiced as early as 1000 B.C. The taking of hostages in ancient warfare was the exaction of an onerous form of involuntary suretyship. The story of Damon and Pythias is based upon a voluntary suretyship, the terms of which were exceedingly burdensome.

Absence of Insurance Principle in Suretyship.—Although the practice of exacting such severe terms has long since passed out, the practice of suretyship with financial guarantees has succeeded it and continued until the present time. Until very recently, however, the guarantee has been by personal surety. Though there were earlier proposals to form a surety corporation, none were actually formed before 1840, and the first company to undertake corporate suretyship in the United States did not do so until 1878.[2] The persons who acted as sureties for others did

[1] Proverbs, 11: 15.

[2] See LUNT, E. C., "Surety Bonds," rev. ed., pp. 3 and 4.

not generally undertake to do so as a business venture. They were not, as the early marine and fire underwriters, attempting to insure a number of risks and take advantage of the operation of the law of large numbers as applied to them. Usually the moving consideration was friendship and personal regard. One person was rarely surety for more than one or two friends. Sometimes there were prospects of reciprocal business preferences or other valuable inducement. But the voluntary character of the surety's action and the suffering frequently resulting were so noteworthy that it became a settled rule of law that the bonds of sureties were to be rigidly construed against claimants, and sureties were referred to as favorites of the law.[1] Historically, therefore, suretyship is not to be classed as insurance.

Surety Underwriting Practices.—The historical evidence against considering suretyship as a form of insurance, though persuasive, is less convincing than that of certain present practices. For example, not infrequently a surety company will decline to issue a bond unless the person for whom the bond is required deposits with it collateral equal in value to the maximum possible loss under the bond. It may be questioned why a person would require such a bond. Certainly not for the same reasons that might lead him to buy a fire-insurance policy. Usually, such a bond is obtained in order to comply with a legal requirement on which the person's right to take some desired action is conditioned. Under it, there is no transfer of risk if the collateral is good (and usually, when taken, it is cash or its equivalent), for the surety can sustain no loss and the depositor stands to lose his whole deposit. Bonding underwriters look upon the writing of these bonds as a lending of credit backing only, and the premium on the bond as a fee for the service involved. It should not be inferred from this example that bonds are issued only when secured by collateral as indicated above. Collateral is required in only a small proportion of any company's obligations, but this extreme type of case, which is by no means rare, is cited to bring out clearly a fundamental difference.

Real Service of Suretyship.—What, then, is the purpose of suretyship? Perhaps this may be seen more clearly by turning back to the practice of private suretyship. Bonds and sureties

[1] See 32 *Cyc.* 72.

have not generally been demanded where the parties making an agreement have confidence in each other, both as to integrity and ability, including financial ability. It was when some doubt crept in that surety bonds were called for.[1] The bond became a certificate of character, ability, and financial worth, an unusually strong one since the surety had risked his fortune on his own estimate of and confidence in the principal. Also, when one person goes on the bond of another, he does so only when he has the utmost confidence in that other. The risk is otherwise too great. It is in line with this theory that, when corporate suretyship was first proposed, it was frequently stated that a corporate bond was less satisfactory than a personal bond, for if a person did not have friends who would back him up, but had to go to a corporation for his bond and pay for it, there must be something wrong.

Thus it appears that, in theory at least, the function of the surety is to prevent loss by certifying those most certainly entitled to confidence, and that the bond is merely a formal backing up of the judgment that such person is so entitled.

Service of Surety Not Changed When Performed by Corporation.—Since the undertaking of the business of issuing surety bonds by corporations, corporate suretyship has largely tended to displace private suretyship. The reasons why this should have come about are not far to seek. A man might be willing to place his own fortune in jeopardy for his friend if his friend's need were great and if he realized that that friend had no other way to meet it. But with corporate suretyship available at moderate cost, he naturally does not feel that he should take the risks involved merely to save his friend the expense of the corporate bond. Again, although the personal surety might be well worth the sum for which he went surety at the time the bond was executed, his fortune may have materially dwindled at the time a demand is made upon him under the bond. Consequently, those requiring others to furnish bonds have tended to specify that the bonds be those of surety companies. Where bonds are required by statute this is often the case.

With this displacement of private by corporate suretyship,

[1] In modern business the surety bond is becoming an established customary requirement.

there has come about some change in the public attitude toward sureties. There is not quite the same sympathy and tendency to construe the bond strictly to protect the corporate surety for hire that there was for the voluntary private surety who might have become the victim of his own good nature. Most surety companies now also write some of the various lines of casualty insurance, and there is, therefore, a natural tendency in the public mind to consider the surety business to be essentially an insurance business.

Most surety underwriters protest that this is a mistaken view. They will admit that, under the stress of competition, almost all fidelity bonds are now written on an insurance basis,[1] but they question whether this is really beneficial to those in whose favor the bonds are written, and they point out other types which could never be written on an insurance basis.

Most businessmen requiring bonds of their employees do not require bonds large enough to cover all possible stealings. There is thus the chance of loss in excess of the bond. But, of more importance still, is the fact that a dishonest employee may injure the business in various ways not covered by the bond, *e.g.*, by bringing a bad reputation to its name, an indirect injury which may be greater than direct stealing. Underwriters protest that a greater service is done employers by keeping them from employing dishonest men through refusing to bond them than would be done by distributing through insurance the loss due to their misconduct. The same reasoning applies to the bonding of contractors and others.

Competition.—Notwithstanding this line of reasoning, it is often convenient for bankers and others employing many people to have bonds written which cover whoever may hold a particular position, rather than a named individual. This is particularly true where there are frequent or sudden changes in personnel. The employer is relieved under such bonds from keeping track of all changes and seeing that suitable bonds are filed by each person appointed to the staff. The surety company covering in this way is not certifying to the competence and

[1] Including the blanket bonds discussed later in this chapter, more than two-thirds of the premium income of the bonding business is from contracts written on an insurance basis.

reliability of those who may be covered by the bond, since it cannot, in the nature of things, have made an investigation which would serve as the basis of a certificate of this kind.[1] Consequently such bonds must be written on an insurance basis, and become in effect insurance contracts. Sometimes these bonds include much more than the ordinary risk of dishonesty of the employee.[2] Competition between the surety companies has led to an extensive development of such "blanket" bonding. Whether this is better for the institutions so covered and the public in general is a debatable question.

Traditional Form of Bond.—The traditional form of surety bond is substantially as follows:

Know All Men by These Presents.
That.............of.............as Principal and.............of ....as Surety are held and firmly bound unto............. of...............in the penal sum of................Dollars to the payment whereof to the said....................they bind their heirs, executors, administrators, successors and assigns.
Whereas the said....................has been employed by the said ....as..........,
Now, therefore, the condition of the foregoing obligation is that if the said....................shall well and truly perform the duty of ....then this bond shall be null and void otherwise it shall be in full force and effect.
Signed, sealed and dated this............day of...........192...

The specification of what will invoke the penalty of the bond varies with the circumstances calling for the giving of the bond. Few are quite so all-inclusive as the example given.

This form, with the necessary and suitable changes to adapt it to the case of a corporate surety, is still in use for many purposes. In some cases, it is specifically stated as the condition of the bond

. . . that if the Principal shall indemnify the Obligee for all loss the Obligee may sustain by reason of the Principal's failure to comply with

[1] Many companies arrange with employers carrying position bonds to have employees so bonded furnish applications and make the same investigations as for individual bonds, giving the employer the benefit of that service.

[2] The details of such bonds cannot be discussed here but the student is referred to special works in this field, for example, Luther E. Mackall, "The Principles of Surety Underwriting," and Lunt, *op. cit.*

any of the terms of the contract, then this obligation shall be void; otherwise it shall remain in force.[1]

This means that, if an obligation arises under the bond, the resources of the principal or his estate are subject to the first call, and the surety is liable only to the extent that the principal fails to make good.

Parties to a Bond.—From an examination of the above form it becomes evident that there are three parties to any bond:

1. The party whose acts and responsibility are guaranteed by the bond. This party is known as the *principal* of the bond.
2. The party who is indemnified if any loss occurs which is covered by the bond. This party is known as the *obligee.*
3. The party who guarantees the performance of the principal and becomes liable with him if any loss occurs. This party is known as the *surety.*

Comparison with Insurance Contract.—From the standpoint of the obligee the bond has much resemblance to an insurance policy, particularly after a loss has occurred. He usually immediately calls upon the surety to make good, especially if it is a corporation, and the latter puts such pressure as it can upon the principal to make good. If he cannot, or will not, do so promptly, the surety pays and makes such recovery as it can from the principal. There is the difference, however, that usually the obligee does not pay the premium on the bond but calls upon the principal to furnish the bond as the basis of the transaction, which will presumably be to his advantage. In this respect the position of the obligee is similar to that of a mortgagee who, as a condition of his loan, requires the mortgagor to provide insurance. It is now the usual practice of employers to pay the premium on bonds guaranteeing the fidelity of their employees.

Here the resemblance to insurance ceases. The premium charge by the surety includes, it is true, some margin for the payment of losses. In the case of contracts written on an insurance basis it is about as large a percentage as in other lines of insurance. But in other cases it is essentially a service fee for the investigation of the principal and the determination of

[1] This language is taken from a bond guaranteeing the performance of a construction contract.

his responsibility, or a fee for the lending of credit. Bonds are given principals when it is practically certain that the obligation under the bond will have to be met, but the company makes sure that the principal will pay by requiring him to deposit with it collateral equal to the penalty of the bond and to make this deposit under an agreement which gives the surety company the right to dispose of the collateral as it sees fit. An example of this type of bond is one filed by the loser in a judicial proceeding to secure a stay of execution pending an appeal. Since in only about 25 per cent of cases appealed is the first decision reversed, it is a reasonable assumption that the appellant will lose. Were such bonds written on an insurance basis the premium would be impracticably high.

It will not be feasible to go into detail in respect to all the various types of bonds issued by surety companies, or the various underwriting safeguards and practices. To emphasize the difference in underlying character between most bonding transactions and true insurance transactions, it may be well here to note one other type of bond and the practice under it, *viz.*, the bond of a fiduciary, such as a guardian of a minor. It is frequently the practice of the surety company to demand, as a requirement before it will issue the bond, that it have joint control of the estate. This, when granted, means that all checks must be countersigned by its representative, and that securities and other negotiable assets must be kept in a safe-deposit box to which the guardian is to have access only jointly with the company's representative.

The peculiarity that brings about these requirements is the fact that a large part of the risk under any bond is a moral risk. There may be a risk of inadequate resources or inexperience under a construction contract bond, but even in that case the risk of dishonesty is also present. The joining of the principal with the surety in the promising of indemnity is, in a measure, a guard against this risk. Collateral and joint control are additional safeguards, but the chief reliance is upon careful investigation of the principal.

Great Variety of Bond Forms.—In any legal proceeding where one party is restrained from exercising his claimed rights pending the determination of the issue, the courts insist that the party

at whose instigation the restraint was imposed file a bond to protect the other party against loss by reason of such interference, in case, after trial of the issue, it prove unjustified. Most public officials are required to be bonded for the faithful performance of their duties. Contractors are nearly always required to furnish bonds that the contract will be carried out according to specifications and that all bills incurred in connection with the contract will be paid. Licensees, such as plumbers and realtors, are usually required to be bonded. Some manufacturers give maintenance bonds to the purchasers of their equipment. In fact, the practice of bonding has become so extensive that there is scarcely any contractual relation between persons which is not at times found to be guaranteed by a surety bond. In the topical index of one book on surety bonds[1] there are listed nearly 300 different kinds of bonds. For most of these the companies have printed forms, but not infrequently cases arise where the entire bond must be prepared by typewriter. With the exception of certain classes of fidelity bonds (bonds guaranteeing the honesty of employees in positions of trust), these forms are adaptations of the basic form quoted above. The differences are mainly in the qualifying conditions of the bond.

Fidelity Bonds and Surety Bonds.—The business of suretyship is usually subdivided into two categories: fidelity bonding and surety bonding, but to the uninitiated the line of demarcation is far from clear. In a broad sense, bonds issued in either category are surety bonds, that is, they are written instruments whereby either by direct statement or by clear implication one party becomes surety for another. They all provide indemnity to a third party, the obligee (or the insured, if the contract is in form an insurance policy), for loss caused by the principal (sometimes called the "obligor") under the bond or by the person covered under the policy. But always he is primarily responsible for his act and must make good if he can. There is a fidelity (dishonesty) element in the risk assumed under all bonds. But in the class of bonds known as *fidelity bonds* that is the only risk. In a large proportion of the bonds classed as *surety bonds* the surety assumes also risks of incapacity, technical or financial or both.

[1] LUNT, *op. cit.*

Looking at it somewhat differently, one recent writer[1] puts the distinction in the following terms:

> All corporate surety bonds are, broadly speaking, divisible into two major classes: fidelity bonds and surety bonds. Fidelity bonds are usually given in security of an implied obligation, while surety bonds are given in security of an expressed obligation, the terms and conditions of which are usually evidenced by some instrument in writing.

The implied obligation secured by the fidelity bond is, of course, the obligation to deal honestly with one's employer.

Surety Bond Forms and Classes.—It is in the second category of bonds that the great variety of forms is found. They all stem from the traditional form quoted on page 245. The major differences are in the language following the word "Whereas" in the seventh line of that form, which language sets forth the expressed terms of the principal's obligation, in security of which the bond is given, either in full or by reference to attached documents, and in the language following the words "if the said .....shall" in the ninth line, which sets forth the violations of that obligation which will invoke the penalty of the bond.

The principal classes of surety bonds are

1. *Contract bonds,* securing the performance of contracts of all kinds, for construction of huge public works like Boulder Dam or the San Francisco-Oakland Bay Bridge, for construction of small private dwellings, for supply of materials, for transportation, and a multitude of other purposes.

2. *Court bonds,* required of litigants who desire to take certain actions affecting the rights of others when their right to do so is questioned or opposed. They fall into two groups:

   a. Those required to protect defendants' rights when a writ is sought—attachment, replevin, garnishment, etc.

   b. Those required to protect plaintiffs when the defendant seeks to interpose a blocking writ—appeal, release of attachment, release of replevin, release of garnishment, etc.

   Underwriters regard the first group as involving only normal credit risks, the second class as more hazardous.

[1] Crist, G. W., Jr., "Corporate Suretyship," p. 24.

3. *Fiduciary bonds,* issued in behalf of persons in positions of trust under court appointment, such as receivers of insolvent corporations or estates, executors of wills or administrators of estates, guardians of minors or incompetents.

4. *Public-official bonds* are principally fidelity bonds, but they are in the usual surety-bond form and sometimes cover losses due more to misjudgment than to dishonesty. For example, a sheriff executing a writ of attachment might through error seize the property of the wrong person. He would be responsible at law for the loss so caused, and the surety shares his responsibility.

Space is not available for detailed discussion of the forms of these bonds, nor does it seem to be called for. With the exercise of a little imagination the student can guess fairly closely the language that would be appropriate to insert at lines 7 and 9 in the form on page 245 to fit the several types of guaranty, though some of it, *e.g.*, in the bond of the receiver of a railroad, might be lengthy and abound in descriptive details.

The issuing of these bonds is looked upon by surety underwriters as a lending of credit similar to the lending of credit by a bank. In some respects the bond resembles the ancient respondentia loan, the precursor of insurance. However, the premium is payable in advance and not afterward at an enhanced interest rate as then. In fact, no interest is charged, for the credit lent is not for working capital but for the sort of service that is rendered by the capital of an insurance company, an enhancement of the confidence of others in the financial responsibility of the principal, from the knowledge that if other resources are not adequate to meet obligations, the capital of the surety may be called upon to serve in the breach.

Surety bonds do not, like insurance policies, contain any provisions relative to the procedure for loss settlement, not even the few simple words of the marine policy "in case of loss, such loss to be paid in thirty days after proof of loss and proof of interest." The reason for this is the same as that for the brevity of the provision in the marine policy. The practice of suretyship is so ancient that custom, common law, and statutes lay down the procedure for enforcing the penalty of the bond.

Modern Fidelity Bonds.—Originally, fidelity bonds also followed the traditional form and were issued individually on

separate application of the principal, with verification of facts through an employer's statement. This practice imposed on each employer the custody of the several bonds of each of his employees and the necessity of watching expiration dates for proper renewal. With a large staff this was no small task and gradually, through the demands of employers and the competition of the surety companies, the practice was changed so that a single master bond was issued to cover all employees who might be bonded, and a schedule attached setting forth, as to each employee, his name, the position in respect to which he was bonded, and the amount for which he was bonded. The traditional form of bond is not adapted to this treatment, and a considerably different form is used. A separate application is called for from each principal, and his name is admitted to the schedule only if investigation develops no unfavorable features. If a man resigns, or if a new employee is taken on, the surety company must be notified, and the schedule modified accordingly. Such bonds are known as *schedule bonds* and are still extensively employed.

Although schedule bonds relieve the employer of much inconvenience, if the concern has many branches and considerable change in personnel, there is yet much detail work in reporting them to the surety. If the report is not made promptly, the new employee is not covered. Employers desire to be relieved of this annoyance and risk. To meet this situation, again under the force of competition, the companies may issue *position bonds* covering whoever may be employed in a particular position until the bonding company gives due notice of its unwillingness to cover him. Although the employer gains in some respects under this type of bond, he loses the service of the surety company in selecting trustworthy people. The surety also has relinquished much of its special advantages. In fact, the bond in this form comes very near to being essentially an insurance contract. But the process has gone even further.

Under a fidelity bond of any of the types mentioned heretofore, the loss must be proved to have been due to the misconduct of some particular employee covered individually or by position under the bond. Often, however, losses due to the lack of fidelity of employees cannot be definitely fixed on particular

individuals. This is particularly true of banks, and the banks desired even broader coverage than that afforded by the position bond. This they sought in the markets of the world and were able to procure from a group of underwriters at Lloyd's, London. After some hesitancy the American surety companies met the competition with an even more liberal form of *bankers' blanket bond.* Although the original intention was to confine the use of this bond to banks, trust companies, title-insurance companies, safe-deposit companies, companies organized by banks to deal in securities, private bankers, and stockbrokers, some of the companies have experimentally extended the field for such bonds to include high-grade mercantile and other similar establishments.

Competition has led to the development of *commercial blanket bonds* which furnish a broad coverage but are not so broad as the broadest forms of bankers' blanket bonds which indemnify even for losses due to misplacement. One form provides indemnity for losses due to "larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, willful misapplication, or any other fraudulent or dishonest act or acts" of any employee of the insured. It is not necessary to identify the guilty employee. If the loss can be traced to any group of employees covered by the bond, it is covered. The bond does not, however, cover loss due to robbery or other acts of strangers, or due to other than dishonest acts of employees within the definition stated. Combination contracts are now issued which do cover these risks also.

Blanket position bonds are also now issued covering, not the entire staff, but only the occupants of named positions. There are various other differences between these two forms. The limits of space in a general text preclude detailed description of any of these forms. Since their development is so recent that important changes from time to time may be expected, the student desiring details should communicate with a representative surety company.[1]

All such contracts may properly be considered insurance contracts. The present forms of individual fidelity bond and bankers' blanket bonds will be analyzed as typical of such insurance contracts as are used in this field.

[1] See Lunt, *op. cit.*, Chaps. VII and XXI.

Individual Fidelity Bond.—The forms of surety bonds are not standardized by law as in the case of fire insurance, nor are standard provisions required by statute,[1] but by agreement between the companies which are members of the Surety Association of America many of the leading forms have been more or less standardized and to some extent forms have been drawn by the insured, *e.g.*, by the American Bankers Association. The individual fidelity bond now bears more resemblance in its general form to an insurance policy, than to the traditional bond form. It names as parties only the bonding company and the employer though, in describing the risk, the employee is named. The consideration is stated to be the premium, and the statements and representations of the employer, but the latter are not otherwise stated to be a part of the contract, and a copy is not attached.

The risk transferred, as it appears in the agreement, is to

> . . . reimburse the Employer for such pecuniary loss . . . as the Employer . . . has sustained . . . by an act or acts of fraud, dishonesty, forgery, theft, embezzlement, wrongful abstraction or willful misapplication on the part of . . . (hereinafter called the Employed) directly or through connivance with others in connection with the duties of any position to which he may be assigned by the Employer during the term of this bond or of any renewal thereof.

It will be noted that, although the list of misdeeds is fairly long, it is only losses through the misdeeds of the named person which are covered, though the indemnity is not limited to cases where he alone was guilty of the misconduct. It will also be noted that the risk is limited to pecuniary loss, but by other language such loss is held to include personal property as well as money and, included in personal property, is that for which the employer is responsible. The loss is limited to an amount not exceeding the named penalty of the bond. But it is not limited to loss from misdeeds while the employee is in a particular position. For, although the employee is referred to as in a particular position, the bond states that it also covers him in any other position to which he may be transferred.

[1] In the case of certain public official, licensee and other bonds running to the state, the form is usually prescribed in the law requiring them.

Formerly, fidelity bonds were issued for fixed periods but renewed by the use of renewal receipts. At the present time they are usually continuous instruments running until canceled by either the employer or the company. There is danger with breaking into periods, that, unless it is otherwise provided in the bond, the liability of the surety might be held cumulative covering up to its named limit in each period. This is provided against by the condition that

> The aggregate liability of the Corporation . . . for or on account of any act or acts of the Employed, shall not exceed the amount for which the Employed shall have been specifically guaranteed at the time such act or acts shall have been committed.

Embezzlement and like crimes are seldom immediately discovered. Clearly the bond should cover misdeeds during its term, whether discovered within that time or not. On the other hand, the surety should have some time after which it may be assured that further claims may not be made. To meet these two requirements liability is limited to losses discovered within 15 months after termination of the bond by lapse, cancellation, death of the employee, or his leaving the service.

A further limitation is that the surety is not liable for a defalcation, the proceeds of which have been used to pay a preexisting debt to the employer; nor is it liable for any default occurring after notice to it of any act that would constitute a claim, and, finally, condonation by the employer of a fraud releases all liability from and after that time. Thus an employer continues a defaulter in his service at his peril. The surety companies do not feel that they should cover a risk deliberately assumed by the employer.

After having given notice of discovery of any act likely to produce a loss (known in the company offices as a "trouble notice"), the employer must, within a specified time, file an affirmative proof of loss under oath, must give the surety all evidence possessed by him, and must give all possible assistance (other than pecuniary assistance) for the purpose of bringing to justice, prosecuting, and convicting the defaulter, and procuring reimbursement. If reimbursement is procured, it was formerly usually provided that it would be shared by the employer

and surety in the proportion of the losses sustained by each.[1] For example, if a person bonded for $10,000 embezzled $15,000, the surety would be called upon to pay $10,000 and the employer would sustain a loss of $5,000 for which he could not be indemnified. If the surety company later recovered from assets of the defaulter $6,000, under the terms of the bond it would retain $4,000 and pay the employer $2,000 leaving a net loss to the surety company of $6,000 and to the employer of $3,000. This clause, of course, applies only in case the bond is not large enough to reimburse the employer in full, which unfortunately often happens.[2] If the employer is fully indemnified, the surety alone is entitled to the recovery, being subrogated to the employer's claim.

The claim is payable 3 months after filing, and there are the usual limitations that suit may not be brought within that time, nor later than 2 years after the right of action accrued.

Cancellation without prejudice to right of recovery by reason of actions that may have taken place is permitted on substantially the same terms as under casualty-insurance policies, but usually the notice must be somewhat longer in advance.

Some forms contain a clause providing for arbitration of claims through a board of three arbitrators: one appointed by the company, one by the insured employer, and the third by these two. In such a case the decision of the majority as to the amount in dispute shall be final. Though designated as "arbitrators," it appears that their jurisdiction is limited to the amount and does not include the question of the act being covered. In this respect their powers are similar to those of the appraisers under a fire-insurance policy.

Schedule Fidelity Bond.—The schedule form is, in its general terms, identical with the individual bond. The significant differences are

1. In the insuring clause, reference is made to the employees

[1] Under conditions of severe competition the tendency is to give the employer all the salvage until he is fully reimbursed. The wisdom and equity of this are doubtful.

[2] It is because of this and the fact that the employer determines the amount for which he will bond any employee that the author questions the wisdom and equity of allowing the employer the full salvage obtained by the company's efforts.

named in the schedule attached instead of to a particular named employee.

2. In fixing the maximum amount of the bond, reference is made to the amount opposite each name in the schedule instead of naming a single fixed amount.

3. In the cancellation clause, provision is made for cancellation with respect to each person rather than the entire bond, but long notice is not necessary for the employer to cancel as respects one employee.

4. A provision is included for adding names to the schedule.

5. The coverage on any person begins with the date opposite his name.

Position Fidelity Bond.—The form of the position-schedule bond follows in general that just described, though it is simpler since it will not in general be desired either to add to the positions covered or to cancel in respect to any of them.

Bankers' Blanket Bonds.[1]—The forms of bankers' blanket bonds are now approved by the American Bankers Association, having been drawn by the surety companies in conjunction with a committee from that organization and approved by it. They are indeed insurance policies and cover much more than the pure fidelity risk. They cover the insured bank against loss of money or securities:

1. Through any dishonest act of any of its employees, wherever committed, and whether committed directly or by collusion with others.

2. Through robbery, burglary, theft, holdup, destruction, or misplacement while the property is within any of their offices covered under the bond, whether effected with or without violence, or with or without negligence on the part of any of the employees.

3. Through robbery, holdup, or theft by any person whomsoever while the property is in transit within 20 miles of any of the offices covered under the bond and in the custody of any of the employees, or through negligence on the part of any of the employees having custody of the property while in transit as aforesaid.

[1] There are several different forms, detailed descriptions of which would require undue space; *e.g.*, one form does not cover "misplacement."

The bond covers any loss up to the amount of the bond and, on the discovery of the loss, is automatically reinstated to its full amount, though, when the amount of the loss has been ascertained and paid, a prorata premium is charged for the amount reinstated for the remainder of the year.

If the bank carries fidelity bonds on any of its employees, the policy provides "excess coverage," *i.e.*, coverage for whatever part of the loss exceeds the penalty of the fidelity bond on such employees, and serves as primary coverage on all other employees as to the losses within its scope.

In case of loss in excess of the limit of the bond, all salvage, whether recovered by the bank or the company, goes to the bank until its entire loss has been covered.

The bond is free from warranties and contains the specific provision that no statement made by or on behalf of the insured, whether contained in the application or otherwise, shall be deemed a warranty of anything except that the statement is true to the best of the knowledge and belief of the person making it.

Individual applications from the employees are not required, only one application, signed by an officer of the bank, being taken. As with the position bonds, the more conservative companies arrange for application from, and make inspections of, individual employees.

The coverage under the holdup and robbery provisions is also much broader than in the ordinary policy.

The liberality of this form is evidence of the result of competition for the coverage of powerful interests.

SUMMARY

1. Suretyship is an older practice than insurance and, in some types, is not based on the insurance principle.
2. The theoretical function of the surety is to serve by weeding out those not capable of fulfilling obligations, giving its financial guarantee only to those worthy of confidence.
3. Fidelity bonding has tended more and more to be written on an insurance basis, and the forms used clearly resemble other insurance forms.
4. The modern tendency, under competition, is toward the issuance of a so-called "blanket bond" to financial institutions,

which is essentially a combination of fidelity and burglary, robbery, and theft insurance.

References

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CHAPTER XV

AUTOMOBILE-INSURANCE CONTRACTS

The insurance of automobile owners against the risks to which they are subject involves no principle not applicable to some one of the lines heretofore discussed. The nature of the automobile, however, changes the conditions of some of these risks and necessitates the use of different forms for their proper transfer to the company. For example, the standard fire-insurance policy limits the coverage of property under it to a fixed location. Since the automobile is made to be moved about, this would be inappropriate. Again, the limitations of the ordinary theft policy make it inappropriate to cover against the theft of an automobile.

For these reasons and because the average person thinks of his automobile as distinct from his other possessions, the insurance of automobiles has come to be considered as a separate line of insurance, and the problems of its administration are such that the companies have set up automobile-insurance departments for dealing with them.

Automobile Risks.—The risks of an automobile owner as such fall into two groups: first, those of damage to, or destruction of, the car itself and, second, that of being called on to respond in damages for injuries which may be done to others through the use, ownership, or maintenance of the car.

The risk of damage to the car itself may again be divided into four classes:

1. Destruction by fire, internal or external in origin.
2. Theft.
3. Injury through collision, with some other object, moving or stationary, or through upset.
4. Other damage to the car as by breakage of glass, damage in a flood, or while being transported.

The risks of being called upon for damages may be on account of injury to persons or to property.

Those transporting persons or goods by motor vehicle as common carriers are subject to the risk of being held responsible for loss of, or injury to, property carried, as well as for death of, or injury to, passengers. This, however, is a peculiar and special interest and is really a phase of inland marine insurance.[1]

Associated Lines of Coverage.—In insuring automobile owners, one class of carriers usually covers the risks to the car, and another the liability risk. But the automobile has become so important that special companies have been organized to give complete coverage to the automobile owner against all risks. In other cases, associated companies have jointly issued combined policies, giving complete protection which neither could give individually, because of charter or statutory limitation.

Fire insurance may be written alone in a separate policy without the association of any other coverage. Although there is no theoretical reason why theft and collision insurance might not also be each separately written in individual policies, in practice this is almost never done. If not combined in a single policy with fire insurance, theft insurance is usually written by a rider or endorsement on a fire policy. Collision insurance is also usually associated with fire insurance, but sometimes it is furnished by endorsement on a liability policy. The transportation hazard is included in the fire policy.

Prior to 1934 no state required the use of a standard automobile-insurance policy. In that year, West Virginia adopted a state standard liability policy, and plans for the adoption of such policies were being advocated in other states. Under this stimulus, the National Bureau of Casualty and Surety Underwriters (an organization of stock casualty-insurance companies) and the American Mutual Alliance (a similar organization of mutual companies) appointed a joint committee to try to work out an acceptable uniform form. This committee developed a set of standard provisions with certain alternatives which effectively constituted a standard liability policy and which were adopted for use in most states from Jan. 1, 1936. Amendments have been made from time to time, but the uniformity of language has been preserved. The property coverages have been similarly standardized, and most private cars are covered under a single-

[1] The general features of these contracts are explained in Chap. VII.

document joint policy affording such of the covers as the insured may elect, the combination policy being issued by two affiliated companies, one of which is a fire company covering the risks to the car and the other a casualty company covering the liability risks. This type of policy is the one discussed in this chapter.

Under the law of negligence the person causing damage is usually responsible therefor, and there is no lien attached to the instrument used unless it be the property of that person[1] and be seized to secure a judgment not otherwise satisfied. If the automobile is the property of another and held by the operator under an uncompleted contract of sale, that other is not subject to risk of loss by reason of claims of those injured in person or property through its use. Hence, there is no incentive to companies financing the purchase of automobiles on credit terms to require the carrying of liability insurance. On the other hand, the destruction of, or any damage to the automobile reduces *pro tanto* the security for their loan. Hence it is usually the practice of these companies to require the borrower to carry fire and theft insurance and almost always, collision insurance, but not liability insurance. As a consequence, single policies covering fire, theft, and collision insurance are frequently found. Such a combination of risks may always be covered in a marine-insurance policy, but not in a fire policy, and it was at first doubted whether they could be covered by a fire-insurance company whose charter did not also authorize it to write marine insurance. Indeed, the first automobile policies were written by a marine-insurance company for that reason. It has now been arranged, by either amendment of statutes or ruling of insurance commissioners, that fire-insurance companies may write such policies, whether or not they are also authorized to do a marine business. Such a combination policy will now be analyzed.

Insurance Against Loss of, or Damage to Car.—The consideration for the policy is the premium and certain declarations which are stated to be the insured's agreements and representations. His agreement is signified by the acceptance of the policy. The declarations state the insured's business and occupation; describe the car by naming the model, year, trade name, type

[1] There is always the possibility that the person driving may be held to be the agent of the owner, who would then be liable.

of body, factory number, number of cylinders, and list price; give details as to purchase, the month and year, whether new or secondhand, the actual cost including equipment and the encumberance or mortgage upon it, if any; describe the use to which the car will be put and the place where it is usually kept when in garage. All of these are facts with which the insured is, or should be, thoroughly familiar. He should of course, check their accuracy before accepting the policy.

Parties to the Contract.—The contract is a personal contract, and by its terms does not cover "while the automobile is subject to any bailment lease, conditional sale, mortgage, or other encumbrance not specifically declared and described in this policy."

Risk Transferred.—In combination form the risks assumed with respect to damage to the car itself are designated and defined as follows:

D. *Comprehensive Loss or Damage to the Automobile, Except by Collision.* To pay for any loss or damage to the automobile, herein called loss, except loss caused by collision of the automobile with another object or by upset of the automobile or by collision of the automobile with a vehicle to which it is attached. Breakage of glass and loss caused by missiles, falling objects, fire, theft, explosion, earthquake, windstorm, hail, water, flood, vandalism, riot or civil commotion shall not be deemed loss caused by collision or upset.

E—1. *Collision or Upset.* To pay for loss or damage to the automobile, hereinafter called loss, caused by collision of the automobile with another object or by upset of the automobile, but only for the amount of each such loss in excess of the deductible amount, if any, stated in the Declarations as applicable hereto.

E—2. *Convertible Collision or Upset.* To pay for loss or damage to the automobile, hereinafter called loss, caused by collision of the automobile with another object or by upset of the automobile. Upon the occurrence of the first loss for which payment is sought hereunder the Insured shall pay to the company the additional payment stated in the Declarations. Loss caused by collision or upset occurring prior to the first loss for which payment is sought hereunder is not covered.

F. *Fire, Lightning and Transportation.* To pay for loss or damage to the automobile, hereinafter called loss, caused (a) by fire or lightning, (b) by smoke or smudge due to sudden, unusual and faulty operation of any fixed heating equipment serving the premises in which the automobile is located, or (c) by the stranding, sinking, burning, collision

or derailment of any conveyance in or upon which the automobile is being transported on land or on water.

G—1. *Theft (Broad Form).* . To pay for loss or damage to the automobile, hereinafter called loss, caused by theft, larceny, robbery, pilferage.

G—2. *Theft (Deductible Form).* To pay for loss or damage to the automobile, hereinafter called loss, caused by theft, larceny, robbery or pilferage, except that $25 shall be deducted from the amount of each loss not occasioned by the taking of the entire automobile.

H. *Windstorm, Earthquake, Explosion, Hail or Water.* To pay for loss or damage to the automobile, hereinafter called loss, caused by windstorm, earthquake, explosion, hail or external discharge or leakage of water.

I. *Combined Additional Coverage.* To pay for loss or damage to the automobile, hereinafter called loss, caused by windstorm, earthquake, explosion, hail, external discharge or leakage of water, flood or rising waters, riot or civil commotion, or the forced landing or falling of any aircraft or of its parts or equipment.

The insured may elect among these and the fact of his election is shown by the entry of a premium in the declarations. A combination of coverage D and E (1 or 2) gives the fullest coverage and is most often chosen.

Coverage is limited by

1. Exclusion of loss due to war damage or confiscation by duly constituted governmental or civil authority.

2. Exclusion of damage due to wear and tear, freezing, mechanical or electrical breakdown, or failure unless it is the result of other losses covered by the policy.

3. Exclusion of damage to robes, wearing apparel, and personal effects.

4. Exclusion of damage to tires unless the damage is by fire or theft or coincidental with other losses covered by the policy.

5. Exclusion of loss due to conversion, embezzlement, or secretion by any person in lawful possession of the automobile under a bailment lease, conditional sale, mortgage, or other encumbrance.[1]

6. Except under the D coverage, by excluding loss due to riot or civil commotion or to breakage of glass if there is other glass-breakage insurance.

[1] D or G coverages. The others would not cover this risk in any event.

7. Exclusion of loss while the automobile is used in illicit trade or transportation.

8. Restriction to a set time period named in the declarations.

9. Geographical limitation to the United States, its territories and possessions, Canada, Newfoundland, and coastal transportation between ports in this area.

10. Restriction to use as stated in the declarations.

11. Limitation to the amount, if any, set up opposite the given cover in the declarations, but in any event to the actual cash value of the automobile or part damaged or lost, or the amount which it would cost to repair or replace with material of like kind and quality.

The company has the right to repair or replace and, unlike the practice in the case of fire loss to fixed premises, usually exercises it.

Miscellaneous Provisions.—The policy provides that the company shall take by way of subrogation any right of action against third parties, as do most other policies, though equity would probably require that such right be yielded in any case where the company paid.[1]

The procedure for loss settlement is substantially the same as under the ordinary fire and liability policies. The insured must give notice of loss, protect the property from further damage, and prepare and file his sworn proof of loss within 60 days. In the event of theft, robbery, or pilferage the insured must also give notice to the police. He must exhibit what remains of his property, submit to examination under oath if required, and produce for examination books, accounts, and such other documents as may be required. These latter requirements are usually waived in the case of an evidently honest claimant. He must give prompt notice of any accident. The insured is also bound to assist the carrier, except financially, in the settlement of claims.

Appraisal is provided for in case there is disagreement as to the values involved, in terms almost identical with the provision in the fire policy.

The policy contains a limitation on the period during which suit may be brought as under the standard fire policy, and a

[1] The insurance under the policy may not inure directly or indirectly to the benefit of any carrier or bailee liable for the loss of the automobile.

clause relating to other insurance similar to that found in the standard fire-insurance policy. Assignment of interest is not binding on the company unless assented to by it.

The policy may be canceled by either party on substantially the same terms as the standard fire policy, except that mailing of notice by the carrier is sufficient evidence of notice.

A sort of business-interruption or loss-of-use coverage is introduced by a provision that, in event of theft of the car covered under the policy, the company will reimburse the insured for the expense of rental of a substitute automobile, including taxicabs not exceeding $5 per day, or a total of $150, or the actual cash value of the insured automobile if less than that sum.

In order that the insured may not be even temporarily without insurance on trading in his car for a new one, the policy automatically covers a newly acquired car provided the company is notified within 30 days and provided the new car replaces the automobile described in the policy or is an addition to one or more cars, all of which are insured by the carrier. The clause granting this insurance provides for adjustment of the premium to correspond to the rate on the replacing model and specifies that the insurance on the old car, in case of replacement, ceases on the date of delivery of the new car. The insurance on the new car is for the remainder of the policy period. The insurance is not extended to a new car if the insured has other valid and collectible insurance on that car.

Liability Insurance.—Since the joint policy is written as a single document, the consideration is as previously described.[1]

Parties to the Contract.—The parties to this part of the contract are the insured and the company named as furnishing these coverages—the casualty-insurance company. In defining the insured, the contract provides:

> The unqualified word "Insured" wherever used[2] . . . includes the named Insured and, except when specifically stated to the contrary, also includes any person while using the automobile and any person or organization legally responsible for the use thereof, provided the actual use of the automobile is with the permission of the named Insured.

[1] See p. 261.

[2] In relation to these coverages.

The reason for this broad definition is that it is customary for an automobile owner to allow other members of his family and, at times, friends or organizations of which he is a member to use his automobile. If during such use someone is injured, he frequently makes his claim against the owner of the car on the theory that the user is the agent of the owner. This has been a source of embarrassment to the insured and the company. In earlier forms, a provision extended coverage to other drivers using the car with the permission of an adult member of the insured's family. This language also caused many difficulties, and in preparing the new form it was decided to restrict the coverage to those who were granted permission by the named insured. The permission need not be given in writing, nor need it be given personally. It may be given through an agent or even implied, but it must emanate from the named insured. Under the older language an adult member of the family might, by permitting the use of the automobile by someone whose use of it was forbidden by the insured, give that person the protection of the insurance. Under this language the insured's wish will prevail at least as respects the benefit of the insurance for which he has paid. The "named Insured" is the person or persons named in the declarations.

The insured other than the "named Insured" is not protected against liability for injury to or death of the named insured, nor does the broadened definition of the insured include garages, parking stations, etc., nor any employee with respect to the injury to, or death of, another employee of the same employer in the course of the employment. Except as to the named insured, the coverage does not apply in connection with the use of trailers unless both the automobile and the trailer are insured in the same carrier.

Risk Transferred.—The bodily-injury-liability coverage is essentially the same as under a general bodily-injury-liability policy, except that it is restricted in its scope to claims for injury due to the ownership, maintenance, or use of the automobile or automobiles in respect to which the policy is written.[1] However, if the named insured is an individual, and the car described in the declarations is owned by him individually or jointly with his wife,

[1] See Chap. XII.

the protection of the policy is extended to the named insured and spouse with respect to the operation of any other private automobile which they may be operating or in which they may be riding if driven by a private chauffeur or other domestic servant. Thus they are insured if temporarily they use the car of a friend who had no insurance that would cover them. There are certain necessary restrictions of this coverage which the policyholder should carefully note. It is the duty of the carrier to investigate claims, defend suits, and pay damages and costs within the limits of the policy. The limits are fixed in the same way as in the general liability policy, at a fixed maximum for any one person injured and a fixed maximum for any one accident. There are, however, certain special limitations and qualifications that arise from the nature of the actions out of which liability may arise.

The policy does not cover liability for injuries or death sustained (1) by any person to whom the insured may be liable under any workmen's compensation law or (2) by any employee of the insured who, at the time of injury, is engaged in other than domestic service or in the operation, maintenance, or repair of any automobile. These liabilities are, or should be, covered by workmen's compensation, or employers' liability insurance, and their exclusion from the scope of this coverage prevents conflicts and disagreements over which insurer may be liable, and relative liability under the contribution clause.

Under the property-damage-liability provisions, the carriers liability does not extend to claims for damage to property of the insured, or in charge of the insured or his employees, or carried in or upon his automobiles. The coverage is also limited to a fixed maximum, usually $5,000 for any one accident.

As to both liability and property-damage coverage, the company is not liable in respect to any automobile:

1. While used as a public or livery conveyance, unless so stated in the application and corresponding premium paid.
2. While towing or propelling a trailer unless it is covered by like insurance.
3. While used elsewhere than within the limits of the continental United States of America (excluding Alaska) and the Dominion of Canada.

These exclusions relate to matters which are within the control of the insured and which materially increase the hazard.

It is not necessary to discuss here the miscellaneous terms of the policy as they have been adequately considered in a previous chapter.[1]

Medical Payments.—Because often when a guest sustained injuries in an automobile accident the insured motorist entered into collusion with him to enable him to collect damages from the insurance carriers, many states have passed *guest laws.* These laws require the guest to show more than ordinary negligence of the operator in order to collect damages, even willful intent. Though thus largely relieved of legal liability, many motorists feel a moral obligation to supply at least such medical care as the injured guest needs. To meet this desire the companies now offer, as an optional additional coverage at a specified premium, a limited third-party accident insurance covering this expense. This insurance may also cover the named insured if he so elects.[2] The clause granting this insurance is entitled in the combination policy "Medical Payments."

Under this clause, the company agrees to pay to or for each person who sustains bodily injury, caused by accident arising out of the use of the automobile while the person is in or upon or entering or alighting from the automobile, the reasonable expense of necessary medical, surgical, ambulance, hospital, and professional nursing service, or in the event of death, reasonable funeral expense, if incurred within one year from the date of the accident.

This benefit is available only if the injury occurs while the automobile is used by or with the permission of the named insured. It is limited to an amount set out in the declarations as applicable to "each person" but not limited as to number of persons. It does not apply to employees other than domestic servants, and not to them while engaged in the operation, maintenance, or repair of the automobile. Nor does it apply to anyone to or for whom benefits are payable under any workmen's compensation law. The clause is available only on policies covering private automobiles used for "pleasure and business."

[1] See Chap. XII.

[2] Except in some states where it is held to be a personal accident coverage which cannot be granted except in a policy conforming to the statutory provisions for such insurance. See Chap. XI.

Dealers' and Garage Risks.—The automobile dealer or garage operator has need of a variety of coverages. He should have fire and theft insurance on his own cars and those for which he is responsible. To protect him fully, the garage-liability policy must include protection against liability for damages on his premises, as in the case of manufacturers, as well as against liability from street accidents, which from the nature of his business may be expected to be more numerous than with private owners, and from liability due to any defect in work done by him which may have involved a customer in an accident.

The combination policy described earlier in this chapter is clearly not suitable for dealer or garage insurance. Though the same combination of companies may cover a dealer or the operator of a public garage, service station, etc., they do not find it desirable to issue a similar joint policy. Separate policies are issued covering the risk to the property of the insured and his liability risks. The basic fire, theft, and transportation policy as issued to individuals is modified by endorsements to meet the particular circumstance of the case, which may vary greatly with the extent and nature of the insured's business. No new principle not heretofore discussed is introduced in these forms.

Three plans of liability coverage are offered:

1. The specified-car plan, which is similar to the coverage offered for private owners. This is used only by small garages for whom alone it is practicable. Even for them it does not give adequate protection.

2. The named-driver plan. This is feasible only where there are but few drivers. The policy covers liability due to injuries arising out of the operation of any automobile by the named drivers while in his employ. Like that under the specified-car plan this coverage is inadequate.

3. The pay-roll plan. Under this plan the premium is based on the pay roll of the garage. The policy gives full coverage against the hazards noted above. It excludes the hazards of elevators, additions or alterations to the premises, the use of automobiles for livery purpose or transportation of passengers or merchandise, or of the use of automobiles in a speed contest. All but the last may be covered either by another insurance policy or by endorsement and payment of suitable additional premium.

Liability for property damage may also be covered by an endorsement.

SUMMARY

1. The insurance of automobile owners against the hazards to which they are exposed is now an important branch of the insurance business of both fire-and-marine and casualty companies.

2. Fire, theft, and collision insurance are usually furnished by fire- or marine-insurance carriers; bodily-injury- and property-damage-liability insurance by casualty carriers.

3. Policy forms are fairly well standardized by practice and agreement among the companies and are substantially uniform in their provisions.

4. The forms used are an adaptation of the forms previously discussed as in use for similar coverage, with such modifications as are appropriate in view of the mobile character of the subject of the insurance and the conditions under which it is operated.

5. Associated fire-and-casualty companies issue a combination policy for private passenger automobiles giving such elements of a complete and comprehensive coverage as the insured elects, each company assuming liability for the coverage that it is authorized to write. In form it is a single policy. Some carriers are authorized to write all kinds of automobile insurance in a single contract.

6. For garage and service-station operators and the operators of commercial automobiles a variety of forms and endorsements are available to cover in "tailor-made" fashion the risks to which they are exposed.

References

Huebner, Solomon S., "Property Insurance," 1938 ed., Chap. XXXIII.
Kulp, C. A., "Casualty Insurance," rev. ed., Chap. 8.
Sawyer, E. W., "Automobile Liability Insurance."

Part III

TYPES OF INSURANCE CARRIERS

INTRODUCTION TO PART III

In Part II, the treatment was largely based on the assumption of one form of insurance carrier, *viz.*, the private stock corporation. Since such a corporation is not ordinarily required to include in its policies any reference to the nature of its organization, or to any relation between it and the policyholder other than that of insurer and the insured, that assumption has served the useful purpose of concentrating attention on the basic aspects of the policies as insurance contracts, without reference to clauses relating to the various types of the insurance carrier, and peculiar to each type. These clauses are substantially the same for a given type of organization in whatever branch of insurance it operates.

It is the purpose of Part III to describe the various types of insurance carriers, their origins and peculiar characteristics, and to indicate the modifications of the policy necessary for each. The chief claims of each type for preference, and the counterclaims of their competitors, will also be briefly examined.

CHAPTER XVI

TYPES OF INSURANCE CARRIERS

On first surveying the field, and observing the keen competition between the several types of insurance carriers, one is struck by their number and variety. On closer scrutiny, however, they are all found to be variants of two fundamental types:

1. A cooperative organization, operated solely, in theory at least, for the benefit of the members.

2. A proprietary enterprise serving as a risk carrier and as a means of profit to its proprietors.

Both of these types are of an origin so ancient as to be lost to memory. The former is a natural product of the instinct of mankind which leads to associations for common defense. The ancient common enemy of civilized man is disability due to disease or accident and, time out of mind, there have existed co-operative organizations which paid various forms of benefits to their members in event of various kinds of misfortune. In the beginning, at least, they were not thought of as insurance organizations, for the theories of probability and of insurance based on the law of large numbers had not been heard of. But they were insurance organizations in fact and, as the need of widespread insurance became realized, it also became evident that similar organizations might meet the new needs, and the principles on which these organizations had operated were adapted, often with considerable changes in detail, to the new condition.

The latter type probably grew out of the credit requirements of enterprising traders. The respondentia loan,[1] carrying a higher rate of interest than the market rate on good security but not repayable if the venture was lost, served when commerce was of relatively small volume. But as the volume increased, the more efficient system of insurance developed. The underwriter took the place of the moneylender as the risk bearer, and the interest rate and insurance premium were separated. At first the insurance was confined to marine risk, though the same underwriters sometimes issued speculative life-insurance policies on the lives of those going on voyages. The London fire of 1666 suggested that the risk of fire might be cared for in the same way, and gradually the range of underwriting extended to the fields it now occupies.

Essential Mutuality of Insurance.—Without implying thereby that the services of the proprietary insurance organization are not necessary in any case,[2] it should be pointed out that there is a certain fundamental mutuality in the practice of insurance. This may be brought out by comparing the conditions underlying the conduct of that business with those underlying manufacturing or trading, in both of which large capital investment is required in the form of buildings and other equipment before any

[1] See p. 102.

[2] For a discussion of its advantages and disadvantages, see Chap. XVIII.

service can be rendered. Also, business may be suspended by either for an indefinite period and, if the physical property is protected against deterioration, may be resumed at will. True, the sales organizations would probably go to pieces, and a new clientele would have to be built up, so that it would be a serious disadvantage to suspend, but it can be done and is done, in manufacturing at least, for no inconsiderable periods.

No extensive physical capital is required in order that an insurance enterprise may serve the public. Legal restrictions aside, all that is required is an underwriting staff properly to rate and select the business, a clerical staff to record transactions, a skilled staff to settle claims, and a competent set of directors to supervise the enterprise and conserve funds. This is a little more elaborate organization than the other types of enterprises require in addition to their physical plants. But the most skilled organization in the world could not serve as insurers unless there were a sufficient number of risks insured to furnish a stable experience under the operation of the law of large numbers. Having acquired a volume of risks, it could not suspend and revive its operations at will. For it could not do so and have at all times the volume of business necessary for successful operation under this law. In short, the insurance business can furnish insurance only by having a body of policyholders. If the comparison may be continued in metaphor, the commodity which the insurance company manufactures (certainty) is produced by natural laws from the raw material (risk) which it can acquire only by doing business. In essence, then, it is the group of policyholders who insure each individual in the group by transferring their individual risks to the common risk bearer.

It follows from this that a properly organized and soundly managed co-operative insurance enterprise should be able to serve society well. But it does not follow that all cooperative enterprises regardless of management must succeed, nor does it follow that it may not prove desirable in the long run to act through a professional risk bearer for profit, if thereby better management is secured. In most states a certain amount of capital is required of a stock insurance corporation, but such capital is required as a guarantee against bad judgment and

catastrophe loss rather than for actual use in the business. Indeed, it cannot be used in the business, for if it becomes impaired the corporation may be held to be insolvent.

Proprietary Enterprises.—There have been three types of proprietary enterprises that have in the past served as insurance carriers:

1. Private individuals and copartnerships operating alone.
2. Private individuals, copartnerships, or syndicates of individuals operating as Lloyd's Associations.
3. Groups of private individuals organized as insurance corporations.

A brief account has been given in Chap. VII of the early activity of private underwriters in marine insurance. The first offices for fire insurance were started after the London fire by private individuals. During the following century several such offices were established. Early records show the existence of private underwriters in colonial America. But they have now passed entirely from the stage.

Lloyd's Associations.—A brief sketch of the development of Lloyd's, London, has been given.[1] This organization is still in existence, has been incorporated, and is still the leading factor in the marine-insurance field. *But the corporation as such does not conduct an insurance business.* It has three essential functions:

1. It is the best equipped marine-intelligence organization in the world. Until recently, it supervised the construction and repair of ships in all parts of the world and rated them in its Lloyd's Register;[2] it maintains records of British captains and periodically publishes a biographical Register; it keeps in touch with maritime affairs throughout the world, publishing in connection therewith an "Index," which is a list of all British mercantile vessels and of many foreign ships, showing the latest reports on their location and condition; and it also publishes a daily "List" which contains shipping news as currently received and is generally recognized as the most reliable authority in this field. It also maintains a record of losses in "The Black Book."

[1] See p. 102.

[2] This work has now been taken over by the Society of Lloyd's Register, a separate entity.

2. It is an organization for loss settlement, and its *agents* throughout the world supervise salvage, repair, and loss adjustments, primarily for its members, though for a consideration they may act for others.

3. It maintains an underwriting room for its members, and, through its Committee, supervises the operations of its underwriting members, and, by deposits of security and scrutiny of their accounts, attempts to assure the soundness of their insurance contracts.

The underwriting at Lloyd's is done by syndicates of individuals usually acting through one attorney in fact for each group. All policies are issued in the name of the individuals as such and are guaranteed by their private resources and standing. All insurance is placed by brokers who are members of Lloyd's and submitted to the several underwriting groups, each of which has a desk in the underwriting room. Frequently, several syndicates will be found on the same policy. The policy expresses the contract as though with a corporation or single group of individuals including the maximum aggregate sum insured. Each signature is accompanied by a fraction indicating the share assumed, and sometimes a stated amount which is that fraction of the sum named in the policy.

Although the underwriters associated at Lloyd's endeavor to see that all contracts are lived up to in good faith and have at times assumed the liabilities of members who have become financially involved, the legal obligation is only that of the several individuals and hence can be enforced only by proceeding against them severally. If one syndicate or member[1] of a syndicate fails, his share cannot be recovered from the other signers of the policy. A characteristic phrase found in all London Lloyd's policies is "Each for himself and not one for another."

Despite this emphasis in the formal contract on individual underwriting and responsibility, the Corporation of Lloyd's has arranged for the accumulation of a large central guaranty fund

[1] The syndicate is usually signed for with a rubber stamp listing the individuals, attested by the signature of the attorney in fact, the stamp showing the proportion within the amount assumed by the syndicate which is taken by each member.

the purpose of which is to protect the name of Lloyd's by taking over the policy liabilities of those of its underwriters who become unable to meet them.

Lloyd's, London, is the chief center for marine insurance in the world, but many other types of insurance are underwritten there. Some underwriters confine themselves to marine risks; others write a wide variety of lines and undertake many spectacular contracts of the type defined in Chap. III as speculative.

From this plan of doing business at Lloyd's, London, the term "Lloyd's" has come to be applied generally to the plan of issuing a single policy whose obligations are borne fractionally by a series of individuals or syndicates in proportions indicated in conjunction with their signature.

Insurance on the Lloyd's plan is permitted in some parts of the United States, but no important part of the insurance business in this country is done by such organizations.[1] In the state of Illinois alone do the laws provide for authorizing Lloyd's, London, to do business here. When contracts are made with the underwriters of that organization by Americans, the contract must generally be made through London brokers in England, subject to English law. Such brokers have correspondents in American cities.

No special provisions need appear in a Lloyd's policy other than the substitution of the words "the underwriters" for "the company" wherever those words appear, with similar formal changes.

Private Stock Corporation.—The laws of most states now provide by general statutes for the incorporation of insurance companies. In general, articles of incorporation specifying the names of the incorporators, the name of the proposed corporation, the number of shares and the par value of each share, and the proposed powers of the corporation within the statutory limits for such companies must be filed with the proper state official and other legal formalities complied with.

When so formed, the corporation is owned by its stockholders who have an equitable interest in its assets and control of its conduct. This control is exercised by the election of a board

[1] American Associations use the spelling "Lloyds."

of directors who, in turn, elect the officers and other managers and, in theory at least, instruct them in the conduct of the business.

Unless otherwise provided by the charter of the corporation and by the laws of the place of incorporation, the profits which may be earned are the property of the stockholders, and may be disbursed to them in the form of dividends at the discretion of the board of directors. Likewise the business losses are to be borne by them. In most if not all states, the loss is limited to the amount paid in the stock,[1] *i.e.*, if the assets will not suffice to pay all the claims, there is in most states no further claim on the stockholders.[2] As had been previously indicated, the capital merely serves as an additional guarantee of the corporation's contracts. Some stock companies issue participating policies granting the holder a right to share in the surplus of the company. This is known as doing business on the "mixed," as distinguished from the proprietary and mutual plans.

In general, no special terms are required in the contract of a private corporation by reason of its character as such, but some states require a statement in the policy regarding stockholders' liability and where required, either by statute or charter provisions, the clause usually appears next to the name of the corporation. It sometimes is printed on the filing back of the policy. When policyholders share in the surplus, an appropriate clause setting forth the right and the time and manner of distribution is required.

The greater part of the insurance in force in all lines, except life insurance, in the United States is written by stock corporations. In the life-insurance field, the greater part of the business is done by mutual companies.

[1] In New York and several other states the original subscribers are required to pay in 150 per cent of the par value of the shares. Conservative financing usually dictates an even larger cash payment. Only a few states permit insurance companies to have "no-par" stock. In recent years a few companies have been organized or refinanced with some classes of preferred stock.

[2] In several cases in the past the stockholders of fire-insurance companies which have sustained conflagration losses so large as to impair or wipe out their capital have voluntarily assessed themselves to provide funds to cover all losses, restore the capital, and furnish a surplus for continuing operations.

Cooperative Enterprises.—There are four types of co-operative insurance carriers:

1. Pure assessment mutual associations, or corporations.
2. Interinsurance exchanges, or reciprocal exchanges.
3. Advance-premium mutual corporations.
4. Fraternal orders.

Pure Assessment Mutual Associations.—The *pure assessment mutual* insurance carrier is more frequently found than any other, for a large share of the rural and "county mutual" fire-insurance companies are of this type.[1] As the individual concerns are small, however, the total volume of insurance in force in this class is relatively small. There are also several accident-insurance companies operating on this plan which have attained considerable size.

The organization is very simple and is based on the idea of mutual aid, every policyholder being a member of the company. Usually the policies are for equal, or nearly equal, amounts, and each member has an equal voice in its control. The affairs are nominally conducted by a board of directors, and there are the usual officers. Not infrequently the secretary is the only paid officer and gives only part time to the work. When a loss occurs the officers, or a committee, adjust the loss, and an assessment is levied on the members in proportion to the amounts of their policies to raise enough to pay the loss. This is the simplest form of such an organization.

The larger organizations of this type usually try to maintain a fund sufficient to pay the claims likely to arise within a certain period in the future, and levy assessments as may be needed to keep the current funds at about the estimated figure. Sometimes (usually in accident companies), there are annual dues assessed to care for the office expense. Sometimes, this amount is raised as a part of the claim assessment. The guarantee of the insurance lies in the right to assess all members.

Unfortunately, organizations of this kind are not always properly run in the interest of the policyholders. Unscrupulous persons have sometimes got themselves elected to office and, by proxies secured in devious ways (even by clauses inserted in the

[1] As the country becomes more settled the tendency is increasingly toward a change in these organizations to the advance premium type of cooperative.

application for the policy), have maintained themselves in office. They have paid themselves excessive salaries, or paid themselves and their friends excessive commissions for securing policyholders. Since they have no responsibility for claims, such persons have everything to gain and nothing to lose except honor and respectability. These abuses have chiefly occurred in accident and life companies.

The policy form for such a company is naturally materially different from those discussed in Part II. Sometimes it consists in a simple certificate of membership in the organization, the details of benefits and obligations being left to the constitution and by laws. In other cases, the policy is, in most respects, substantially the same as for a stock corporation. In all cases, however, it is necessary to prescribe the manner in which the insured may be called upon for assessments. Some of the states have standardized the policy forms of assessment fire-insurance companies.

Reciprocal Exchange.—The reciprocal exchange has some of the characteristics of an assessment association and some of the characteristics of the Lloyd's plan of proprietary operations. From the latter fact, they are sometimes erroneously referred to as Lloyd's Associations. The exchange is an unincorporated body known by some name such as the "subscribers at the X Y Z Indemnity Exchange," and the business is conducted by an attorney in fact. The person taking out a policy of insurance becomes by that fact a member or subscriber of the exchange and, in his application, signs the power of attorney which authorizes the attorney in fact to conduct the business of the exchange and among other things

> . . . especially to exchange contracts of indemnity with subscribers of the X Y Z Indemnity Exchange; and in the subscriber's name to make, issue, modify, or cancel contracts therefor containing such terms, warranties, and agreements as the attorney-in-fact shall deem best.

In accordance with this power of attorney the policies are issued by the attorney in the name of the subscribers who are the actual insurers of each other's contracts. Some policy contracts attempt by their terms to make the liability joint and not several, and to limit that of any subscriber to 100 per

cent additional to the premium stated. There is some doubt as to the validity of this restriction on the amount or character of the liability.

As the possibility of assessment is used as an argument against reciprocal insurance by competing carriers, the operators of exchanges have sought in various ways to meet it. In at least one state (California) the law has been amended to permit the issuance of *nonassessable* policies. If the exchange has surplus equal to one and one-half times the minimum capital required of a stock corporation doing the same kind of business, upon certificate by the Insurance Commissioner to that effect, its subscribers are not subject to assessment. At any time thereafter that the commissioner finds there is not such a surplus, he must revoke his certificate. Thereafter no policy may be issued or allowed to remain in force beyond the date fixed for the next payment of premium without written endorsement providing for assessment liability. When this is done, the exchange appears to take on some of the characteristics of a mutual or even stock carrier without, however, becoming a corporation.

It is the usual practice of such exchanges to keep a separate account with each subscriber, to collect and to credit his account with a premium or "deposit" paid in advance. Some reciprocals, mainly those serving a small number of large risks, also credit the subscriber with his share of interest earnings. The account is then charged with its prorata share of the expenses and losses incurred during the policy term. If these exceed the deposit, additional payments are called for; any credit balance is returned to the policyholder at the expiration of the policy, frequently subject to the retention of a portion as a contribution to surplus of the exchange. The surplus is used to iron out irregularities in loss experience or to take up investment losses. Some exchanges writing workmen's-compensation insurance have provided in their articles of association and power of attorney that the advisory board may determine the manner of participation of the subscribers in the distribution of surplus of the exchange even when the articles provide for setting up individual accounts in the manner described. The operators of these exchanges seem to have a theory of consolidating the surplus in the individual subscribers' accounts into a common fund and its subsequent

redistribution according to a formula that takes into account in part the experience of the individual subscriber. The effect, of course, is that losses and expenses are not charged to subscribers prorata. Legally the exchange is set up as a matter of contract between the subscribers, and provided the terms of the contract are not contrary to public policy or statute law, the contracting parties are free to choose their own terms.

Generally the power of attorney appoints the designated manager " . . . to be Attorney-in-Fact for the Subscriber and in the Subscriber's name and stead to do all things that he the Subscriber might or could do with reference to this contract, or any renewal or transfer thereof." This clause, with the clause previously quoted, which generally follows it, places very large power in the hands of the attorney in fact. Sometimes there are also articles of agreement of membership in the exchange which govern its general conduct and, in such cases, there is usually provided an advisory committee chosen in accordance with such articles by the subscribers and having powers as provided therein. In the best of the exchanges such committees have powers approximately equal to those of the board of directors or trustees of a corporation.

The attorney in fact is usually paid a percentage of from 25 to 40 per cent of the gross premiums or deposits collected and, in consideration of this payment, he agrees to defray certain of the expenses of operation of the exchange. The details vary considerably according to circumstances. In some cases, the exchange is an adjunct to a trade association and is practically an attempt to adapt the assessment plan to the conditions of the business world to which that plan as used in other circumstances is ill adapted. In other cases, the exchange is promoted by the attorney in fact as a private enterprise. In that case rarely is there an advisory board with any real power, and often the attorneyship is incorporated. Except as he may be bonded, the attorney is then almost a private proprietor with no liability for losses (because it is not he who is insuring but the subscribers) with a chance to make such profits as he can from the excess of his commissions over his expenses, and with no one to question his judgment on the acceptance of risks for the exchange or the settlement of losses.

The relation between a reciprocal exchange and its attorney in fact has perhaps been no more clearly and forcibly described than in the following language taken from an opinion of the United States Circuit Court of Appeals.[1]

> To constitute an association within the meaning of the act, it is not requisite that each constituent should be coordinate or hold the same relation. A very important indispensable element here is the so-called "attorney in fact," who is not merely and simply an attorney in fact as ordinarily understood. With the attorneyship there is coupled a decided interest which permeates and colors the entire plan. It is the attorney who in practice and by contract inspires and dominates it, and around whom the business is built. His power is irrevocable. He is not removable, and his power of substitution is limited only by a veto of a so-called "advisory committee" which the subscribers annually choose, and which has practically no other material function save that investment of funds by the attorney is with the advice and consent of the committee. The attorney has absolute power over who may be accepted as subscribers; what the rates of indemnity shall be; what the subscribers must pay from time to time (limited presumably, by the necessities of the concern); the cancellation of contracts; and thus the ending of the subscribers' relation; the settlement and payment of losses, compromise of claims; and, in practical effect, every power of a corporate board of directors, plus many important powers which such boards do not have . . . .
>
> It is thus apparent that this functionary is far more than an attorney in fact. He is the very pulsating heart of the concern, the subscribers supplying the blood . . . .

In the following chapter more attention will be given to the relative advantages and disadvantages of this type of insurance carrier.

The policy changes brought about by the nature of the organization, in relation to naming of parties, etc., are as follows:

[1] *Pickering v. Alyea-Nichols Co.* 21 Fed. (2nd) 501 (1927). The suit was for recovery of taxes paid under protest on the theory that the exchange as an association of persons was not subject to the tax. Alyea-Nichols Co., an Illinois corporation was the attorney in fact for Belt Automobile Indemnity Assn., a reciprocal exchange. The power of attorney provided that the attorney was to receive certain policy fees and 10 per cent commission on premiums and, subject to confirmation by the advisory committee, authorized it to designate its successor.

1. There is always an application for the insurance, because it is necessary to secure the signature of the insured to the power of attorney for the attorney in fact. This is the most important difference between the application used by an exchange and that used by a corporation.

2. In naming the parties to the contract in the execution clause and elsewhere in the policy, references to the company are changed to refer to subscribers, or to the attorney in fact, or to both.

3. In the consideration clause, in addition to application and premium, the power of attorney is mentioned.

4. In the insuring clause, an effort is sometimes made to make the liability joint only, and not joint and several.

5. A separate clause is inserted defining the insured's liability in relation to the others in event of loss, in relation to reserves, and otherwise.

6. Usually there is a clause providing for consolidation of suits against subscribers, should such be necessary, to avoid a multiplicity of suits.

7. A clause is inserted providing for the manner of accounting for premium deposits, and for refund of balances or making of extra calls.

8. A special cancellation clause adapts the standard provision for return of unearned premiums to the peculiar practices of the reciprocal system.

Reciprocal exchanges are naturally not adapted to the conduct of a life-insurance business and do not attempt it.

The Mutual Corporation—Full-advance-premium Type.—The third type of co-operative-insurance carrier endeavors to collect a full premium in advance[1] and, although in some cases providing for possible assessments, endeavors so to conduct its operations that assessments will not be required. The largest companies in the world (life-insurance companies) are of this type. Owing to the reserve system they do not provide for assessment.

The form of organization of such companies is much like that of a stock corporation, save that the policyholders take the place of the stockholders. At the annual meeting of policyholders a

[1] See p. 284 *in re* nonassessable policies.

board of directors or trustees is elected. Their function, as in a stock corporation, is to elect the officers and supervise them in the conduct of the company's business.

Sometimes the plan of doing business is so similar to that of the stock companies that only those who have carefully studied the business know that certain companies are mutual rather than stock companies. In other cases there is a sharp difference in the manner of conducting the business, and bitter antagonism has developed between the two types, stock and mutual.

Whatever profits there may be are the property of the policyholders, there being no stockholders; and in case of a deficit, the policyholders are subject to assessment. The most successful of this class of companies in the field of fire insurance have a clause in the policy giving the company the right to assess up to five times the premium, yet they have never had occasion to levy an assessment, despite the fact that they have been involved in several large conflagrations, suffering severe losses.

In most, if not all, states the law now provides that such companies, if they have a surplus over and above all liabilities equal to the capital required of stock companies writing the same kind of insurance, may issue nonassessable policies. These provisions of the law were introduced within the past 30 years on the initiative of the leaders of an association of such companies. Most of the mutual companies that can qualify now issue nonassessable policies. This is due to the pressure of their agents to meet the curious and illogical objection of prospective policyholders to an assessment clause. The objection seems to this author illogical because assessment is resorted to only if the company cannot meet its obligations. In that case the same person who fears assessment might be the one who has a pending loss which cannot be paid but which might have been paid from the proceeds of an assessment. In that case he has accepted a risk of a much larger loss than any probable assessment. It is usually the agent of the competing stock company who raises the assessment bogie. Of course, since the stockholders of a proprietary company are not subject to assessment, the insured in a weak stock company accepts the same risk of an uncollectible loss. Many mutual companies have surplus equal to many times the minimum required to issue nonassessable policies. To the policyholder of

such a company the additional protection of the right of the company to assess all its members in case the surplus fails is insignificant. Likewise the probability of the feared assessment by such a company approaches the vanishing point. In the latter part of the past century there were many life-insurance associations and fraternals which ignored the scientific principle of the reserve system and used arbitrary reserves and assessment clauses. The failure of these schemes did cause suffering among those who relied on them. This has not yet passed from the memory of many and may be an explanation of the potency of the assessment bogie.

The laws of several states provide for the organization of mutual life-insurance companies with a guaranteed capital to be retired when the company has attained a certain strength and standing. Although such laws still stand on the statute books, they have not been availed of in recent years. Many of the large mutual life-insurance companies were so initiated. Provision is also found for conversion of stock life-insurance companies into mutual companies by purchase and retirement of stock.

The policy appropriate to a stock company requires little change for use by this type of company. Ordinarily but two additional clauses are required

1. A brief clause providing for the assessment liability, if any, which, for reasons to be explained in Part IV, is not required in the case of a mutual life company.

2. A clause providing that the policyholder shall share in the surplus of the company and prescribing the time and manner of distribution. Sometimes, a clause appears giving notice of the annual meetings of the corporation and the voting power of the policyholder.

Fraternal Orders.—The *fraternal order*, a type of insurance carrier combining social interest with risk bearing, is found in the United States as well as abroad in the field of life and disability insurance.[1]

The membership of the fraternal order is gathered in local organizations, known as lodges, chapters, courts, etc., for social,

[1] In some states fraternal orders may be organized or operated to insure their members against fire. Their operations are usually limited to the insurance of small isolated risks.

educational, and other purposes as well as insurance. To qualify as this type of carrier under the laws of most states, the order must operate on the lodge system and have a representative form of government and ritualistic work. It must be organized for the mutual benefit of the members and not for profit. Members are elected and admitted to the local bodies in accordance with the constitution, laws, and regulations of the supreme governing body, usually with secret initiation ceremonies.

The supreme governing body is a grand lodge or convention known by a name associated with the ritual of the order and usually meeting once in two, three, or more years. Representation in this body is usually by the officers or other elected representatives of the local lodges. The constitutions of the various orders differ in setting up the supreme body, but usually the vote of the several lodges is more or less in proportion to their membership. The supreme body lays down the general regulations for the order, including the terms of the contracts to be issued, the rates to be charged, and other like prescriptions, within the limits set by the laws of the states within which they operate.[1] It also elects the grand officers and grand trustees (known by various titles) who are responsible for carrying out its policies in conducting the affairs of the order during the interim between grand-lodge sessions. The head office of the order is under their direction in much the same manner as that of a private corporation is under its officers and board of directors.

The head office usually employs state and district managers and organizers who work with the officers and members of the local lodges in procuring new members and otherwise promoting the good of the order.

The collection of premiums and dues from the members, as well as the investigation of claims, is usually in the hands of the local lodges, the treasurer of the local lodge reporting monthly to the head office. The local lodges do not settle claims but investigate and report to the head offices. Sometimes the local lodges are permitted to accumulate and administer local funds for granting supplementary benefits to their members.

The fraternal-life-insurance movement began in the United States with the founding of the Ancient Order of United Work-

[1] State laws regulating fraternal insurance are to a great extent uniform.

men (A.O.U.W.) by John Upchurch at Meadeville, Pa., in 1868, and has had a rapid growth. This particular order extended throughout the United States and had many imitators. By the beginning of the twentieth century the fraternal movement was widely extended. It probably furnished life insurance to larger numbers than did the regularly organized companies. But the business was generally conducted on an unsound nonactuarial basis. The consequent increasing cost and disappointment of the older members, becoming apparent at about that time, tended to discredit the movement. The development of the automobile, good roads, the motion picture, and other modern forms of entertainment also tended to weaken the social attraction of the local lodges. The development of group insurance further provided for many of the class who were formerly largely attracted to fraternal insurance. Nevertheless many orders continue to exist with large membership. Some have assets exceeding 100 million dollars.

Until 1911 fraternal orders were subject to regaultion in but few states, and in most of these the regulation was of little importance. As the result of legislation recommended by the National Convention of Insurance Commissioners at its meeting in Mobile, Ala., in that year and modified by a conference held in New York the next year, fairly uniform regulations now exist in most states. Under the spur of these regulations the orders have generally readjusted their plan of operations so as to place them on a scientific actuarial basis and have since made solid progress.

Competition among the Several Types of Carriers.—Not all these types of organization are adapted to all kinds of insurance. They are not all found in most fields, but some of them are found in nearly every field, and in some fields all of them are found. When the several types are working in the same field, the keenest kind of competition prevails. The competition is particularly keen among stock companies, full-advance-premium mutuals, and reciprocal exchanges. This is largely due to differences in selling-organization plans, particularly the manner of compensating local representatives, which are characteristic of each type. This will be dealt with more fully in Chap. XVIII.

In some fields of insurance the state has entered as an insurance

carrier. Sometimes it has reserved that field as a monopoly for itself. Sometimes it competes with the other forms of carriers. State funds are considered in Chap. XVII.

SUMMARY

1. Types of insurance carriers fall into two groups:

   a. Proprietary, embracing private underwriters (an obsolete type), Lloyd's organizations, and joint-stock companies.

   b. Cooperative, embracing assessment mutual associations, reciprocal exchanges, mutual corporations (full-advance-premium plan), and fraternal orders.

2. The Lloyd's plan is essentially the taking of risks by syndicates of private underwriters in their individual capacities.

3. The stock corporation is similar to the stock corporation in other lines of business.

4. The assessment association collects for the loss after it occurs, though it sometimes maintains a fund for prompt payment of claims and levies its assessments at more or less regular intervals as required.

5. The reciprocal exchange is composed of all its policyholders underwriting in a syndicate of individuals and operating through an attorney in fact as a manager.

6. The advance-premium mutual corporation is a company of which each policyholder is a member. Such corporations endeavor to charge an adequate premium; if it proves inadequate, the policyholder may be subject to assessment and, if it proves excessive, the policyholder shares in the surplus earned.

7. Fraternal organizations, consisting of local lodges federated under a grand lodge, serve as insurance carriers in the life- and disability-insurance field.

8. Originally operating as assessment mutual organizations, without state regulation, the fraternals attained great importance but encountered great difficulty because of unsound plans.

9. In the past quarter century fraternals have been subjected to regulation and have placed their affairs in a much sounder condition. They still occupy an important place in the life-insurance field.

10. Very keen competition exists between the several types of carriers, and the prospective policyholder should weigh carefully their relative merits.

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CHAPTER XVII

SELF-INSURANCE—STATE FUNDS—SAVINGS-BANK LIFE INSURANCE

As an alternative to protecting himself by insurance in one of the types of organizations discussed in Chap. XVI, the individual exposed to a given risk may elect to carry his own risk or self-insure. He also sometimes has the option of taking insurance in a fund established by the state or national government for the purpose of making such insurance.

Self-insurance.—An illustration was given in Chap. III of a condition where the individual items in respect to which a particular concern is subject to risk are sufficiently numerous, similar, and isolated to give adequate play to the law of large numbers within the experience of the concern itself. In such a case the intervention of an insurance carrier is not necessary, and the concern can gain all the advantages of insurance by setting aside a fund to take up the fluctuations and irregularity of its loss experience and save the expense involved in the use of an insurance company. Such a method of handling the problem of risk may properly be termed *self-insurance.* Often, however, insurance is not taken although these conditions are not present and no fluctuation fund is set up. It is a misnomer to refer to this as self-insurance. It is rather *noninsurance.* Self-insurance should not be undertaken without careful consideration to determine whether the conditions necessary for its success are present. Even when they may reasonably be considered present, it is generally desirable to safeguard the fund by appropriate excess insurance, similar to reinsurance of a direct-writing carrier.[1]

State Funds.—The term *state insurance fund* or *state fund* has been used to designate two quite distinct types of funds. Sometimes states have undertaken self-insurance to cover the risk of

[1] For a discussion of the meaning and place of reinsurance, see Chap. XXI, pp. 395–399.

loss by fire or other casualty of the state's property. This has been done by setting up a fund from which to pay the losses, usually by appropriating annually to it a sum equal to the premiums that would be charged for such insurance by stock companies. This fund has been designated as a *state insurance fund.*

Several of the states have also set up funds in which the citizens have the option of insuring or are compelled to insure against certain types of risks. Such funds have been established for life insurance, bank-deposits insurance, hail insurance, and workmen's-compensation insurance. In some states the state fund has been given a monopoly of such business. In others, state funds have been established as competitors of private stock and mutual companies.

State and National Life Insurance.—In 1911, the Legislature of Wisconsin[1] enacted a law providing for the establishment of a life fund for the issuance of policies of life insurance to residents of that state. The state assumes no liability other than the fund itself. The state treasurer is the treasurer of the fund, but it is operated by the Insurance Commissioner's office. The rates are sufficient to assure solvency, and the only expenses chargeable to the fund are for clerical help, since the other services are performed by state offices as a part of their regular duties. The fund has no agents, but applications may be submitted through state factory inspectors, clerks, and treasurers of counties, towns, cities, and villages, and state banks, whose duty it is to transmit the application to the Insurance Commissioner.

The first policies were issued in October, 1913. Though the fund has remained solvent and furnished insurance at a very low rate, in 10 years it had issued less than 500 policies. By Dec. 31, 1943, it had only 1,692 policies in force with a face value of $3,071,270. At the same date it had assets of $903,903, liabilities of $808,281 and surplus of $95,622.[2] This confirms other evidence that life insurance must be sold. Apparently the public will not buy it without urging.

United States Government Life Insurance. National Service Life Insurance.—The risk of injury or loss of life of those

[1] Chapter 577, Laws of 1911; in effect June 7, 1911.

[2] *75th Annual Report of the Commissioner of Insurance of the State of Wisconsin* (1944), p. 210.

actively engaged in warfare is such that they are not acceptable risks for life- and casualty-insurance companies. Therefore, among the war measures passed in 1917 was one establishing, in the Treasury Department, a Bureau of War Risk Insurance which was to provide at cost such insurance only for those enrolled in the Army or Navy. The insurance was 1-year-renewable-term insurance, on the step-rate plan, the rate increasing slightly each year. Under the original terms the insurance might be continued on the original plan for 5 years after the signing of the proclamation of peace, but must then be converted to a permanent form. The time for conversion has been several times extended. There was considerable confusion and mismanagement in its early history, as was perhaps inevitable under the circumstances. Soldiers and sailors were urged by their officers to take the insurance as a provision for their dependents, and an enormous volume was written.

By act of Congress approved Aug. 9, 1921, establishing the Veterans' Bureau, the function of the Bureau of War Risk Insurance were transferred to the Veterans' Bureau. At June 30, 1921, there remained in force 651,054 policies for $3,849,375,735 of insurance of which 397,890 policies for $2,980,660,235 were yearly-renewable-term insurance, and the remainder converted to a more permanent (whole-life or endowment) form, though a considerable part was 5-year term. The permanent (converted) insurance is known as United States Government Life Insurance. By later enactment the Bureau was authorized to grant new or additional United States Government Life Insurance to veterans of the First World War and to members of the armed forces up to a limit of $10,000 at any one time. At June 30, 1944, the total United States Government Life Insurance in force was 578,641 policies for $2,494,900,099 of insurance.

There is set up in the United States Treasury a United States Government Life Insurance Fund as a trust fund administered by the government as trustee for the sole benefit of the policyholders. The insurance is legal-reserve life insurance on a participating basis. The government pays all the cost of administration as well as claims due to the extra hazard of military or naval service. The policies all provide permanent- and total-disability benefits for which no extra premium is charged. The premiums

for the entire contract are the net premiums[1] on the basis of the American Experience Table at 3½-per-cent interest. Losses on account of disability benefits are considered in determining dividends, but no extra charge is made on those groups which have not developed sufficient funds to meet the full reserves for both life and disability benefits.[2]

National Service Life Insurance.—A new system of life insurance for persons on active duty with the military and naval forces (including the Coast Guard) was set up by the National Service Life Insurance Act of 1940, which also terminated authority for granting the United States Government Life Insurance referred to above. The insurance is voluntary and available to those in active service without evidence of insurability if the application is made within 120 days of entrance into the service, but upon application thereafter evidence of good health is required. The insurance is upon the 5-year-term level-premium plan convertible on any premium date into ordinary-life or 20- or 30-payment life insurance. The premiums are based on the American Experience Table and 3 per cent interest and are net premiums. The government pays all the cost of administration. The whole-life (including limited-payment-life) insurance policies carry the usual loan and nonforfeiture values and carry waiver-of-premium benefits during continuous total disability of 6 months or more duration prior to attaining age sixty. No extra premium is charged for this benefit. The act specifies that

> The United States shall bear the excess mortality cost and the cost of waiver of premiums on account of total disability traceable to the extra hazard of military or naval service, as such hazard may be determined by the Administrator (of Veterans' Affairs).

The insurance may be issued in any multiple of $500. The limit of insurance to any one person is $10,000, including any United States Government Life Insurance he may have. The insured is entitled to designate his own beneficiary within certain closely limited family relationships. The benefits are payable in equal monthly installments. If the beneficiary is under thirty years of

[1] That is, they provide only for mortality cost and not for expenses of administration.

[2] *Annual Report of the Administrator of Veterans' Affairs for the Year* 1944, pp. 21–24.

age at the time the benefits become payable, 240 installments are payable. If the beneficiary is thirty or more years of age, the installments continue for life. If the beneficiary dies before the whole 240 installments are paid, they do not rest in the beneficiary's estate but continue to the next beneficiary.

The insurance is administered by the Administrator of Veterans' Affairs, and there is set up in the Treasury a permanent trust fund, the National Service Life Insurance Fund, into which premiums and interest earnings are paid and from which benefits and surrender values are paid.

To June 30, 1944, there had been issued 15,285,575 policies for $114,623,201,000 of insurance, an average of $7,498.78. In contrast to the action of some at the close of The First World War, the life-insurance companies and their representatives are urging returning veterans to maintain their National Service Life Insurance.

These plans of insurance are admittedly wartime measures and are not set up to take the place of or compete with the offerings of regular life-insurance companies. They were set up because regular life-insurance companies are unable to cover war risks. Of course, to the extent that their service life insurance meets the needs of veterans the market for regular life-insurance sales will be curtailed, but such insurance may lead the policyholder to become a prospect for additional coverage.

The conclusion from this discussion seems to be that the state does not well serve as a life-insurance carrier or at least cannot do so unless it actively engages in selling life insurance. As the cost of selling is the major cost in this field, and as private enterprise seems better adapted for salesmanship, there is little occasion under peace time conditions for the state to undertake the business.

Although the United States War Risk Bureau was not organized either to reform evils in the conduct of life insurance or as a general social experiment, it has apparently has an important and far-reaching effect. It has focused public attention and discussion on life insurance, the soundness of its foundations, and the value of its benefits, as probably nothing else could. This has undoubtedly been an important factor in producing the large volume of life insurance written since the First World War,

though other factors, such as general prosperity, the influenza epidemic, inheritance taxes,[1] and the like have had their part.

State Bank Guaranty Funds.—In 1829, New York instituted a safety-fund system to protect the notes of insolvent banks. The drains caused by the panic of 1837 rendered it insolvent, and the law was repealed. A similar experiment in Vermont, started in 1831, failed from the same cause. There was no further effort along these lines until the rise of the Populist Movement toward the close of the century. The agitation did not produce action until the losses in the panic of 1907 gave added impetus. Oklahoma passed an act, in 1907, requiring all its state banks to contribute to a safety fund to protect the depositors in banks that failed. The constitutionality of the law was tested and upheld by the United States Supreme Court.[2] During the next decade similar laws were passed in seven other states in the West and Southwest. Of the total five were compulsory and three optional.

The banks were required to make initial deposits into the fund and were subject to subsequent regular assessments until the fund reached a certain level. Then assessments were to be dropped until necessary to restore the fund. Depositors in insolvent banks were given certificates of indebtedness redeemable from the fund if the fund were not sufficient to pay immediately in full.

The depression of 1920 placed very heavy burdens on these funds. In several states, the laws were repealed or amended to permit the banks to withdraw. Withdrawal of banks in these latter states caused the funds to be abandoned. Those still existing are working out heavy deficits.

These funds were all exposed to too heavy a concentration of risks at one time and over a limited area, which was the one most adversely affected by the deflation. They were generally known as "guarantee funds" or "systems" rather than insurance funds, and the need of applying insurance principles to them does not seem to have been considered by their authors. Officials of

[1] Such taxes must be paid in cash and promptly. Often great sacrifice might be required to convert property into cash for this purpose. Provision of a suitable amount of life insurance is an ideal way of assuring cash for this purpose.

[2] *Noble State Bank v. Haskell*, 219 U. S. 104 (1910).

the states involved seem convinced that the system puts a premium on incompetence.[1] In a general public system the moral hazard seems to be too great and uncontrollable.

More recently some of the states have established guaranty funds for securing public deposits. These are in the nature of self-insurance funds.

Federal Deposit Insurance.—The Banking Act of 1933 provided for both temporary and permanent insurance of bank deposits, setting up the Federal Deposit Insurance Corporation for that purpose. The temporary plan, which was originally intended to have been of but 6 months' duration, was kept in effect until August, 1935.

In the meantime, the Banking Act of 1935 was passed, which provides for deposit insurance up to a maximum of $5,000 for one depositor. The insurance is through the Federal Deposit Insurance Corporation, and the banks are assessed annually one-twelfth of 1 per cent of the average daily deposit liability, payable semiannually. The corporation is managed by three directors, the Comptroller of the Currency, ex officio, and two others appointed by the President. The capital of the corporation was obtained by requiring each Federal Reserve Bank to subscribe to the extent of one-half its surplus on Jan. 1, 1933 (a total of approximately $140,000,000), and the Federal Treasury was authorized to subscribe to the extent of $150,000,000. The corporation is allowed to issue obligations to the extent of three times the amount received for its capital and its 1936 assessments, enabling it to raise about a billion dollars in case of emergency.

It is the evident intent to include within the insurance system the whole banking business of the United States, though after 1941 commercial banks having deposits of $1,000,000 or more must become members of the Federal Reserve System to be eligible for insured status.

The corporation is given extensive supervisory powers over the insured banks. It may prohibit the payment of interest on demand deposits and regulate the rate to be paid on time and savings deposits. It may examine insured banks (with the

[1] See opinions quoted by David McCahan, "State Insurance in the United States," footnotes, pp. 219 and 220.

written consent of the Comptroller of the Currency in the case of national banks and of the Board of Governors of the Federal Reserve System in the case of state member banks) and, after written notice and hearing, publish that part alone of the report relating to recommendations not complied with. For persistence in unsound practices it may bring the facts regarding any bank to the attention of the Comptroller of the Currency or the state banking authority having supervision and, after notice and hearing, deprive the bank of its insured status. Deprivation of its insured status in the case of a national bank requires the Comptroller of the Currency to appoint the Corporation as receiver for the bank. In the case of a state bank, its membership in the Federal Reserve System is forfeit. In both cases all depositors must be notified, though the insurance on existing deposits continues for 2 years.

Of course, the time since this plan has been set up is too short to furnish evidence of how it may work over a period of years. Some, familiar with the earlier state experiments, are very critical; others are less pessimistic. In contrast with the state experiments are to be noted (1) the strong financial backing of the capital and borrowing power of the corporation to meet emergencies, (2) the broad spread of risk, covering the whole country rather than only isolated regions, all units in which are exposed to risk from a common cause, (3) the strong powers vested in the corporation for regulatory measures to decrease risk.

The ultimate fate of the system will probably depend on how these regulatory powers are exercised. If they are wisely used in the spirit of "safety first," not only may the plan be successful as an insurance plan but, vastly more important, a far more healthy banking system may result.

State Hail-insurance Funds.—In 1911, North Dakota provided for a state hail-insurance fund. Insurance in the fund was optional. The rates fixed by law proved inadequate, so that losses could not be paid in full. The fund, therefore, proved unsuccessful.

In 1919, a new law was passed providing for a semicompulsory state hail fund which had some unfortunate years, but it wrote

about 90 per cent of the hail insurance in that state and had, in the 5 years, 1919 to 1923, paid nearly $19,000,000 in indemnity.[1] Under the 1919 law the tax rate for the hail insurance was uniform over the state, but this was inequitable as the risk was far from uniform. In 1923 the law was amended to provide for districting the state and setting the rate for each district according to the hazard. In 1933 the law was again amended so that the farmer must elect to take the insurance, rather than be automatically insured unless he declined before a set date to be insured. The assessor of each district is, however, required when making his general tax assessment to explain the operation of the hail-insurance law and to take the application for insurance if desired. The farmer who has not applied through the assessor may make an application to the county auditor or direct to the fund between June 1 and July 15. The insurance is therefore no longer semicompulsory, but its solicitation by the tax officials is compulsory, and this probably helps to prevent the adverse selection that is encountered when the farmer must take the initiative in seeking insurance.

At Dec. 31, 1943, the fund's annual report showed a surplus of $3,403,140. During the year 1943 it wrote 15,434 policies for $11,623,714 of insurance on 1,544,271 acres, collected in taxes and cash premiums $1,062,713, and paid losses of $1,283,086. This was an unfortunate year in which some loss in surplus was sustained. The figures are cited as evidence of the size of the fund. Its operating expense is low and, on the whole, since 1919 it appears to have been successful. The states of Colorado, Montana, Nebraska, and South Dakota have similar funds though they are not so large. The North Dakota fund may be taken as typical.

Under the North Dakota plan a flat tax of 1 cent per acre was levied each year on all tillable land in the state to create a surplus for the hail-insurance fund[2] until a surplus of $4,000,000 was built up.[3] The fund is operated by a manager under supervision

[1] See *Annual Report of Hail Insurance Department of State of North Dakota for* 1923.

[2] At first 3 cents per acre, but reduced in 1923 to 1 cent.

[3] In 1935 the amount to be retained as permanent surplus was reduced to $3,000,000 and the excess of $1,038,865.41 which had been built up to

of the Insurance Commissioner. The indemnity offered by the fund is on an acreage basis and, at the option of the farmer, may be either $5 or $8 per acre. If the original application was for $5, it may be increased to $8 on application before July 15 and before a loss has occurred.

On the occurrence of hail damage, the loss is adjusted by the representatives of the fund, and a warrant is issued on the State Treasurer. In October, after the close of the season, the Insurance Commissioner is required to estimate the tax required to pay the outstanding warrants and expenses of the fund. This amount is then levied as a tax on those insured and is payable in March, as are other taxes. This is called the "indemnity tax." The statute fixes a maximum tax rate in any one year at 10 per cent, but provides for graduation by districts. In operation the law has been interpreted to permit the rate in certain districts to exceed 10 per cent, provided the total levy does not exceed 10 per cent of the amount at risk in the state. It is the apparent theory that the surplus is to take up the balance in bad years. The provision for this use of surplus had not been made in 1923, and losses of that year had temporarily to be settled at 80 per cent of their amount, until a special act was passed in 1925 permitting the use of surplus to pay the other 20 per cent.

The outstanding features of this scheme are

1. Insurance with the state is arranged by the tax assessor in connection with the annual tax assessment.
2. The premium is collected as a tax through the taxing machinery of the state.
3. The state does not guarantee the insurance except through the surplus of the fund.
4. The amount of insurance is limited and must be one of two amounts per acre.
5. There is no selling cost, and the expenses of management are very low.

In other states where the primary listing is on the initiative of the farmer, the funds have not attained such importance. Particularly where the levy is made at the end of the season there is no reason why a compulsory or semicompulsory fund should not always be able to pay its losses, if the statutory maximum tax

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Dec. 31, 1934, was transferred to the State Equalization Fund. At June 30, 1944, it had not yet been returned to the Hail-insurance Fund.

is not set too low. The absence of selling cost represents such a saving as will offset a considerable extra cost which might be incidental to such inefficient management as usually characterizes governmental business and to loose adjustment and overpayment of losses.

The greatest disadvantage is the inflexibility of the system in providing only two fixed rates of indemnity. Removing restriction on indemnity would add to the operating cost, for it would open the door to moral hazard and adverse selection. Most farmers would probably let the listing stand at the automatic limit. Those anticipating more severe losses would probably increase the amount. To guard against such adverse selection and treat all equitably, careful underwriting and more precise rate making would be necessary. This requires skill and experience and would have to be paid for. There is, of course, always the danger of political favoritism in loss settlement and in granting insurance, though there seems to be no evidence of this in North Dakota.

Federal Crop Insurance.—Private insurance not successfully solving the problem of general crop cover,[1] Congress passed, in 1938, as Title V of the Agricultural Adjustment Act, the Federal Crop Insurance Act, setting up the Federal Crop Insurance Corporation and appropriating $100,000,000 for its capital. In practical operation it was administered as a quasi-bureau of the Department of Agriculture. Expenses were to be paid by the government. Originally it was authorized to insure only wheat, but by amendment in 1941 it was authorized to extend insurance to cotton and other crops. Insurance was offered on wheat in 1939, 1940, and 1941, and in 1942 on wheat and cotton. Premiums and losses were payable in kind to keep the yield hazard separate from price movements and were on a quantity basis only, regardless of quality. The indemnity offered was for the deficiency of the harvest under 75 per cent of the normal or average yield. The insurance was voluntary, and about 18 per cent of the wheat acreage was insured for the years 1940 and 1941, and less than 10 per cent for the year 1939. There was evidently a strong adverse selection, and the losses for all 3 years were greatly in excess of the premiums.[2]

[1] See p. 146.

[2] See Clendinin, J. C., "Federal Crop Insurance in Operation."

The bad experience led to a strong movement in Congress to abolish the program, and the 1944 and 1945 Agricultural Appropriation Acts, providing funds for the fiscal years ending June 30 of each of the years named, stipulated that the capital funds provided could be used only to liquidate existing contracts on wheat and cotton crops planted before July 31, 1943. The act was further amended in December, 1944, removing the restrictions imposed by the appropriation acts and providing for insurance on wheat, cotton, and flax planted in 1945 and for trial insurance in 1945 on corn and tobacco in not to exceed 20 representative counties, and in subsequent years on other crops. This program is still in the experimental stage. It is intended that the scheme shall ultimately be self-supporting. No part of the capital may be used after crop year 1949.[1]

War-risk Insurance.—Losses due to war are generally excluded from private insurance contracts.[2] With the introduction of submarine warfare in the First World War the peril was so greatly increased that the marine-insurance market became demoralized, and the belligerent as well as neutral governments set up war-risk-insurance bureaus. Aside from the soldiers' and sailors' life-insurance system no other war-risk insurance scheme was set up in the United States during that war. In the Second World War the personal insurance of soldiers and sailors was covered as described above,[3] and two other schemes were set up.

Marine War-risk Insurance.—In the Merchant Marine Act of 1920 there was set up a revolving fund in the United States Treasury to be used by the United States Shipping Board to provide insurance as it deemed necessary, on the interest of the United States in ships sold by the Board subject to mortgage. Title II of the Merchant Marine Act of 1936 vested in the Maritime Commission provided for by the act to succeed the Shipping Board, all the powers of the Board, including the use of the revolv-

[1] Public Law 551, 78th Congress, 2d Session. Summarized in U.S. Government Manual, 1945, issued by the Office of War Information.

[2] The perils clause of the marine-insurance policy includes war risks, but in practice, when war is declared or strongly threatening, the underwriters have excluded them by endorsement, covering them, if at all, by another endorsement at an extra premium.

[3] See pp. 291–294.

ing fund for insurance. In 1940, the act was amended,[1] designating the fund as the Marine and War-risk insurance fund and authorizing the Commission to provide, directly and by reinsurance, war-risk insurance to United States shippers. At that time it prohibited insurance on vessels or cargo if contraband was carried. Early in 1942, the United States then being at war, this restriction was removed. The operation of the fund was a war secret and particulars are not available. There was some writing of war risks by private carriers, but the great bulk was carried by the fund operated by the War Shipping Admimistration. Published rates for war-risk insurance fluctuated as war conditions changed, but the influence of the government action in stablizing the market was clearly evident. This government action was not in competition with private insurance but rather in cooperation. There is no reason to suppose that the scheme will be continued except, perhaps, as in the Maritime Act of 1920, to cover the interest of the government in ships that it may sell on credit terms.

War-damage Insurance Other Than Marine.—On Dec. 13, 1941, at the request of the Secretary of Commerce and with the approval of the President, the Reconstruction Finance Corporation set up, under Sec. 115 (d) of the R.F.C. Act, the War Damage Corporation with a capital of $100,000,000 to meet the demand for insurance against war damage. By an act approved Mar. 27, 1942, section 5(g) was added to the R.F.C. Act specifically providing for the War Damage Corporation and its functions.

The Corporation insured individuals "against direct physical loss or damage to the property described in the attached application which may result from *enemy attack including any action taken by the military, naval or air forces of the United States in resisting enemy attack.*" The policy followed in its general terms the fire-insurance policy so far as applicable. The Corporation used in its operations the existing insurance facilities of the fire- and casualty-insurance business. Fire- and casualty-insurance companies willing to serve were appointed *fiduciary agents* of the Corporation for the purpose of issuing policies, collecting premiums, and assisting in adjusting losses, and were authorized to use agents and brokers as in their usual practice to place the

[1] Public Act 677 of the 76th Congress.

insurance. Premiums collected by the fiduciary were held in trust for the Corporation and deposited weekly in the nearest Federal Reserve Bank to the credit of a special War Damage Account. The fiduciaries were required to keep a complete separate system of books, records, and accounts which were the property of the War Damage Corporation. Monthly reports were made to the Corporation. The contract with the fiduciary provided that it should check proofs of loss as received from the Claim Service Offices and certify them to the custodian bank for payment. The producer's commission was limited to 5 per cent. The fiduciary had a 10 per cent underwriting participation.

Though the producer's fees scarce paid the expense of dealing with their clients and writing up the policies, they did a good patriotic job. In 1942 about 6,000,000 policies were issued for approximately 140 billion dollars of insurance. About 1,000,000 policies were not renewed in 1943, and the amount of insurance in force dropped to about 126 billion dollars. As of Dec. 31, 1943, the Corporation had received about 218 million dollars in premiums after paying all expenses. Claims had been made for $72,899.74. On Mar. 31, 1944, all policies in force were automatically continued without further payment of premium for 1 year from their expiration date, and on Feb. 28, 1945, all policies then in force were similarly extended 1 year from their expiration date without further payment of premium. As of the present writing[1] these policies are still in effect, though with the close of hostilities the risks have terminated.[2] The Corporation is still in existence, and there is some uncertainty as to liabilities for damages in the Philippines. Practically, the Corporation's work is done, and it will undoubtedly be liquidated along with other war agencies.

State Workmen's-compensation-insurance Funds.—State workmen's-compensation-insurance funds, whether monopolistic or competitive, are usually under the administrative control of the state commission supervising the operation of the workmen's compensation act,[3] which appoints the manager and staff and

[1] October, 1945.

[2] Theoretically, there may still be balloon-borne bombs released from Japan during hostilities which may cause fire damage!

[3] See Chap. XIII for discussion of relation of commissions to workmen's compensation laws.

otherwise acts as does the board of directors or trustees of a stock or mutual corporation. In some states there is now provision for appointment of a body of policyholders to serve as directors or advisors.

Under the monopolistic laws, insurance with the fund is usually compulsory unless permission is granted for self-insurance. The classification of risks is sometimes set up in the law and sometimes left to the management. Class rates are usually made up from statistical data derived from the experience of the fund. Sometimes an attempt is made to adjust rates closely to the hazard and sometimes, in view of the monopoly, close adjustment is not attempted. Usually the premiums are not collected by the taxing agencies but by the fund itself. The claim procedure is much the same as in a private company. In general, the insurance is nonparticipating, *i.e.*, the rates are low and there is no refund at the end of the year, but, if there is a surplus, a reduction of future rates may be made.

The competitive funds find it desirable to organize in much the same manner as stock or mutual companies. In fact, it is not inappropriate to liken them to mutual companies, operated by the state, which usually offer no state guarantee but refund dividends if the rates prove higher than necessary to pay losses and expenses. The policy is very similar to that of a private company, but there is no assessment liability.

Since the states disclaim any liability beyond the fund itself and since insurance with it releases the employer from all liability for payment of compensation, there is no one to whom injured worker claimants can look for indemnity should the fund fail; but it is inconceivable that any state would fail to recognize the moral obligation of making good the payment of claims against the fund under such circumstances. A monopolistic fund could make good a deficit by raising rates, but a competitive fund is not in a position to do so. Most of the competitive funds, however, have substantial surpluses at the present time, so that the question of guarantee is of little practical importance.

State compensation-insurance funds that have soliciting staffs pay them regular salaries and do not pay commissions to agents.[1]

[1] Some state funds do not solicit; others have branch offices whose managers give part of their time to solicitation; still others have employees

Owing to the strong arguments against it used by its competitors, the employer insuring with the state fund usually does so only after careful investigation, and the business is correspondingly persistent, bringing about a proportional reduction in expense. In that respect the state fund is in a situation similar to that of a strong mutual company.

Usually the competitive fund is given a monopoly of the field of public corporations (cities, towns, etc.), which gives a nucleus of business at all times. This is claimed by competitors to be an unfair advantage.

Arguments for State Insurance.—Proponents of state life insurance have generally argued that the conduct of the business by private enterprise involves needless competitive expense and that the establishment of the state fund is necessary to furnish, at the lowest possible cost, this real economic necessity from which the State benefits as well as the individual.

Opponents have pointed out the clear evidence that life insurance will not "be bought over the counter" but must be carried to the individual, urged, even forced upon him, and that the selling cost is justified by the missionary work.

Undoubtedly there is some waste energy in competitive selling, but this is relatively small in comparison with the total cost. Probably the worst feature of such competition is overselling or lack of adequate explanation and fitting of the insurance program to the needs and capacity to pay of the insured, leading to excessive lapse and surrender ratios. If the lapse occurs before the policy has paid its own cost, this results in loss to the company, which means greater expense charges to persisting policyholders. Since the surrender charge in the early years is large, this also results in loss and dissatisfaction to the surrendering policyholder. Also there is reason for saying that insurance is sold in some cases in such small amounts as to do little good, *i.e.*, to be largely wasted in costly funerals, new clothes, and the like; although the cost in these cases may have imposed a hardship. How far this takes place is uncertain. Such cases have been reported by social-service workers. On the other hand, there are cases

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whose major, if not sole, job is solicitation. In no case is the soliciting staff numerous.

where what has seemed utterly inadequate insurance has provided the means to start a family on the upgrade.

At any rate it does not appear that state insurance is the remedy. The few who took insurance from the state fund on their own initiative would probably be more persistent. It seems doubtful that the representatives of a state fund, if it entered upon a selling campaign, would do a better job in working out suitable life-insurance programs than is done by the representatives of private insurance under present conditions. Rather, the need would seem to be for better education of agents and policyholders in life-insurance principles and in the use of economic resources. The private carriers are realizing this and are endeavoring to train agents to be something more than just salesmen. There is also a strong trend toward rating an agent's business for quality and persistency and basing his remuneration in part on indices indicative of the degree to which his business possesses these characteristics as well as upon the manner in which he services his business.

The arguments for and against state hail insurance have been discussed. North Dakota is almost exclusively an agricultural state. In another community with more diversified industries, the argument might well be raised that what is done for one should be done for all, that all should be taxed to create a surplus for a fire-insurance or some other insurance fund, and the fund be operated by the state. Forced to its logical conclusion, the argument for state hail insurance leads to the establishment of a state insurance fund for meeting all the insurance needs of all citizens. Such a fund could undoubtedly be made to work, though it would require many safeguards against adverse selection and moral hazard. But it is not in accord with the theory and spirit of American political institutions. There is, however, precedent in the government operation of the post office, and in postal competition with the private express companies, as well as municipal operation of waterworks and street railways.

In the case of workmen's compensation, the situation is somewhat different from that of either life or property insurance. The state imposes the burden of workmen's compensation and insurance against it on all employers, with the exception of certain classes. If such insurance is not obtainable by certain employers,

their work cannot go on. It is possible, and sometimes happens, that all private stock and mutual companies, either through conspiracy or otherwise, will decline a particular risk.[1] This would drive the owner out of business. If the business were so hazardous that such would be the result, it might be best that society be deprived of products bought with such blood cost or that the processes be reformed to a safer standard by such force. But this view has not been advanced. It is argued that the state, having required insurance, must see that the means are available for complying with that requirement. It is argued further that it is necessary to see not only that the means are available but that they are available at reasonable cost.

Organized labor has consistently argued for monopolistic state compensation insurance. The major argument of this group is that there is no place for private profit in connection with the injuries of the worker. They have maintained that the stock companies, in striving for profits, will be niggardly in claim settlements and unfair to the injured worker, and have cited past abuses in certain cases under personal accident-insurance policies. They have also alleged that the desire to return large dividends to employers will have the same effect on mutual companies. And they point further to the economics of monopolistic operation, arguing that the whole premium charged the employer is what he regards as the cost of insurance, and that he will not object to more liberal benefits if the total cost is still low relatively to that of his competitors.[2]

For the competitive state fund, it is argued that it is necessary to set an example of fair and liberal claim treatment and efficient organization, as well as to assure every one an opportunity to insure.

Arguments against State Funds.—Against the state funds it is argued that the whole idea is "un-American." The precise meaning of this word is debatable, but those using it seem to

[1] In several states which have no state fund the private carriers have arranged pools to provide insurance for those who cannot get insurance otherwise. For service purposes the risk is assigned to one carrier. Hence these pools are called *assigned-risk pools*.

[2] In at least one state the operations of a monopolistic fund have appeared to be more in the interests of low cost to employers than liberal benefits to workers.

mean that it is contrary to our political ideas for the state to undertake what is, or has been, done by private enterprise. This does not seem to be wholly justified, as the examples previously cited show. The cases where the government has conducted such operations have been where they have been natural monopolies or great public conveniences. The workmen's-compensation-insurance business certainly comes within the latter class.

It is also argued that state insurance is unnecessary. Here the case seems to be better founded, at least as to the competitive fund, for in certain states where no state fund is found conditions are admittedly on a par with the best.

A further argument is that the fund will become the football of politics. That politicians will try to use it cannot be gainsaid. Its fate will then depend on public sentiment toward it, on conditions of the civil service, and on the interest of its policyholders in rousing public sentiment to protect it, or in frightening a political management into good behavior.

Again it is argued that if it is kept out of politics, the stifling atmosphere of civil service and budgetary restrictions will kill its spirit. The effect of these things cannot be denied, yet state funds have grown and made a good record despite such handicaps, when the managers have had the courage to carry on and grimly fight for a better opportunity properly to conduct their work.

It is argued that state funds, concentrating on economy, do not show the same interest in the work of accident prevention and risk improvement which is more important than compensation. It cannot be denied that the monopolistic funds have failed here. Some of the competitive funds have made a splendid record in this respect, while others have found it impossible because of budgetary limitations.

The employer in the monopolistic state has no choice of methods of insurance unless his scale of operations justifies self-insurance and the state law permits. In some cases, when his resources do not so justify, he may secure that privilege and procure reinsurance with a stock or mutual company. In the states where competitive state funds exist he will find it desirable to consider the net cost of state insurance in comparison with stock and mutual insurance, taking due account of dividends and also to consider the type of preventive and other service rendered.

It hardly seems likely that the result, in the light of about 30 years of competitive operations, will be the elimination of either state funds or private carriers from the field. There is reason to believe that the competition of mutuals and state funds has been a powerful factor in preventing increased cost due to competition for salesmen.

Savings-bank Life Insurance.—Following an extensive investigation into life-insurance practices by a committee of the New York Legislature in 1906, in the course of which the heavy expense involved in the conduct of life insurance on the weekly-premium (industrial) plan was emphasized, the late Louis D. Brandeis induced the Legislature of Massachusetts to pass an act[1] permitting the savings banks of that state, which are nonprofit trustee institutions, to establish insurance departments for the issuance of life-insurance policies, under certain provisions which would assure that such insurance would be on safe lines and at low cost. The act provided for a central governing board picked from among the trustees of the several banks who should be responsible for the general working plan of all the banks, a single state actuary, and a single state medical director, who would serve all banks. The bank establishing a department was required to obtain by subscription a guarantee fund on which the same interest would be paid as paid to depositors, and which was to be retired when a surplus equal thereto had been built up by the insurance department of the bank. Four per cent of the total premiums of each bank was to be paid into a central General Insurance Guaranty Fund for all the banks until it reached $100,000 after which it could provide the required guarantee for a new bank. This point was reached in 1921, and since then the fund has provided the guarantee funds for new banks. Originally no single policy was to exceed $500. This limit was raised in 1916 to $1,000, but one person might hold policies with several banks. The banks have set a total limit of $25,000 for any one person.

Under Brandeis' leadership the Massachusetts Savings Insurance League[2] was formed, with former Gov. W. L. Douglas, a shoe manufacturer, as president. This league promoted passage of the law and the adoption of the plan. The banks were not

[1] Chapter 178, Laws of 1907. There have been subsequent amendments.

[2] Later incorporated as Massachusetts Savings Bank Insurance League.

enthusiastic about it in the beginning. Between 1908 and 1912 only four banks established insurance departments, though some others acted as agents for them in placing insurance and collecting premiums as did some important manufacturing establishments for the service of their employees. No other bank established an insurance department until 1922. By Oct. 31, 1945, thirty-one banks had established departments. The system grew very slowly at first. Ten years after the first bank established an insurance department the total savings-bank life insurance in force had not reached $10,000,000. It took 26 years to reach $100,000,000. By Oct. 31, 1945, there was over $260,000,000 in force.

During the early years of the system propaganda for it was carried on by the League and cooperating employers through addresses at meetings and distribution of literature. The expenses of the office of the State Actuary and State Medical Director were borne by the state. The law also provided for the General Insurance Guaranty Fund to which each bank contributed and which guarantees the obligations of all banks and forms a basis for pooling mortality experience. The system is supervised by the state through the office of the Insurance Commissioner and the Division of Savings Bank Life Insurance. In 1915 that division was authorized to employ two instructors to present the plan to workers. Through the maintenance of that office, as well as the State Actuary and State Medical Director, the state furnished a considerable subsidy in the early years for supervisory, administrative, and promotional work. In 1927 the banks were required to reimburse the state for some expenses, and in 1929 a program of progressively increasing reimbursement was adopted so that from 1934 on the system has borne all its own expenses. There is no direct selling by solicitors or agents paid either by salary or commission.

In 1938, the banks having insurance departments formed the Savings Bank Life Insurance Council for the purpose of coordinating their activities and assuming certain functions previously performed by the state. The Council carries on a general advertising program through the preparation for distribution of leaflets and pamphlets by banks, credit unions, and employer agencies. It also sponsors some advertising over radio stations

and in newspapers. The extent of the advertising has grown with the system.

The banks are required to keep their savings and their insurance departments separated, and the assets of neither department are liable for the obligations of the other. The banks issue ordinary-life, limited-payment-life, endowment, and renewable-term insurance policies, single-premium immediate, and annual-premium deferred annuities. They limit the amount of annuities which an individual may buy to $100 income per month in all banks. The policies are similar in their terms to those issued by life-insurance companies. The nonforfeiture provisions begin earlier and are somewhat more liberal as there is not so high an initial expense to be recouped before a policy pays its own way. Premium payments may be made monthly, quarterly, semiannually, or annually at the option of the insured. Brandeis was impressed by the fact that the regular depositor in a savings bank might well pay his life-insurance premium at the same time and place. Apparently the savings of expense by this method as compared to the house-to-house collection of industrial-insurance premiums was what led him to advocate the system. A popular plan among the banks and their policyholders is one in which the policyholder authorizes his bank to pay his premiums regularly from his savings account.

The business of the banks has now grown to substantial proportions. The insurance is all participating, and the expenses are low. The result to policyholders is sound insurance at low cost. Representatives of regular life-insurance companies, particularly agents and agency supervisors, complain that the system involves unfair competition, a not unusual complaint of those first in any field against entrants with a new idea. It is significant that the volume of ordinary and industrial life insurance in force in Massachusetts life-insurance companies has continued to grow, though whether at a lower rate than it would have had savings-bank life insurance not been established, it is impossible to say.

Similar legislation was passed in New York in 1939 and in Connecticut in 1941. The extension of the system has been strongly advocated as a public service by those of the "advanced" liberal persuasion. It received considerable publicity in the

T.N.E.C. hearings, and the U. S. Bureau of Labor Statistics has issued two bulletins on it.[1] A bill to provide for the system was introduced in the California legislature in 1939 with the backing of Gov. Olson, though in that state savings banks are proprietary institutions. Bills have also been introduced in several other states.

So long as the system is surrounded by proper safeguards as in the Massachusetts, New York, and Connecticut laws, there appears to be nothing unsound about it. As a part of the general movement toward cooperative effort for economic conduct, it seems likely that it will grow and spread and that perhaps its competition with stock and mutual life-insurance companies will lead to further improvement in life-insurance service.

Though its selling campaigns have followed different lines from those of the regular life-insurance companies, the success of the system does not seem to negative the proposition that life insurance is rarely bought by persons in good health. It must be sold. Often it requires continuing attention to keep it sold.

SUMMARY

1. State funds have been established
   - *a.* As self-insurance funds to cover fire or other risks on state property.
   - *b.* As a means of furnishing to citizens:
     - (1) In competition with private corporations,
       - (*a*) Life insurance.
       - (*b*) Bank-deposit insurance.
       - (*c*) Hail insurance.
       - (*d*) Workmen's compensation insurance.
     - (2) As a state monopoly,
       - (*a*) Workmen's compensation insurance.

2. State life-insurance funds have not developed any material volume of business and do not appear to be needed.

3. A state fund can probably furnish insurance against hail losses and many other kinds of property risks at a lower cost than private enterprise if it can be made semicompulsory. The

[1] *Bulletin* 615 in 1935 and a revision of it as *Bulletin* 688 in 1941 from which much of the information for this section was derived.

difficulties attending this are probably not insurmountable in themselves. Such state activity is contrary to American political theories and traditions, and present circumstances do not seem generally to call for or justify it.

4. A better case can be made for the necessity of a state fund in workmen's compensation insurance, owing to the compulsory character of the insurance.

5. Monopolistic state funds for workmen's compensation insurance have shown low costs but have not been active in accident-prevention work. Their administration has tended to reflect the wishes of the group (workers or employers) in political control in the state.

6. Some competitive state funds have been admirably administered; others have been on a par with mediocre private companies.

7. State funds generally show a saving in cost to employers.

8. The state does not guarantee state-fund insurance but, in the case of workmen's compensation insurance, the facts of the case are such that it is morally bound to make good in case of insolvency. The monopolistic fund can be kept solvent by gradual adjustment of rates. The competitive funds generally have a surplus, and their lower cost of operation gives them a better margin to survive a period of low rates than the stock companies.

9. Beginning in Massachusetts in 1907, there has been a growing movement for savings-bank life insurance, sold, principally but not solely, to savings-bank depositors without personal solicitation by agents.

10. The federal government has established and maintains an extensive system of life insurance for members of its armed forces and for continuance of insurance taken by veterans while members of the armed forces.

11. The federal government also operates

- *a.* The Federal Deposit Insurance Corporation insuring bank deposits.
- *b.* The Federal Crop Insurance Corporation insuring farmers against crop failure, though this insurance is limited in its operations and is still in the experimental stage.

12. As wartime measures it also set up
    a. A marine and war-risk insurance fund to provide marine war-risk insurance.
    b. The War Damage Corporation to insure property in the United States and its possessions against physical damage by enemy action.

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CHAPTER XVIII

TYPES OF CARRIERS COMPARED

With so considerable a variety of organizations offering their services in the insurance field, it must be evident that, by careful study of the relative merits of the several types, a person requiring insurance may obtain his insurance on better terms than by acting only on the representations of the salesman of a particular carrier. Likewise, he may avoid pitfalls into which the unwary might fall by considering price differences alone. In this chapter the outstanding points of strength and weakness of the several types will be considered.

Private Underwriter.—As was indicated in Chap. XVI, private underwriters do not now conduct the business of insuring in this country. Indeed, in few if in any states would the statute permit them. The fact of their passing into the limbo of things forgotten may reasonably be considered to be due to their plan of operation not meeting the test. A review, therefore, of the weaknesses may point the way to avoid other errors in relation to insurance problems.

The following are essential weaknesses that contributed to the elimination of this class of carriers:

1. It would be practically impossible for an individual underwriter to secure a widespread business as cheaply as a corporation, if he could do so at all. In the absence of a wide spread of business, he would be exposed to severe shocks in conflagrations, epidemics, and the like against which his private fortune would not be a sufficient guarantee.

2. There is no assurance to policyholders that individual fortunes will not be dissipated in other enterprises.

3. On the death of an individual his business must be wound up, and policyholders might be forced to replace the insurance at most inopportune times.

Perhaps the entire matter might be summed up by saying that the corporation is a better vehicle for nearly all forms of business

of a trustee or public-service type and that, therefore, the individual operator is eliminated as a competitor.

Lloyd's Associations.—Lloyd's Associations do not operate generally in the field of life, accident, or health insurance, though certain contracts in these fields have been written by underwriters at Lloyd's, London. Such business as is done by them is in the fields of fire, marine, and other types of property insurance. They play no important part in the insurance business of this country.

Although the name is derived from that of the famous old London organization because of similarity of plan, it does not follow that all Lloyd's Associations offer the advantages of that one. In general they do not. The weaknesses of individual underwriting noted above apply also to them, though with diminishing force dependent upon the strength of the articles of association, the size of deposits with trustees, and similar safeguards which may be adopted to protect their contracts. If there are corporation members, the question of their charter powers to undertake the business of insuring should be investigated by a prospective policyholder.

If attention is confined to Lloyd's, London, the following points may be noted as favorable:

1. There is a tradition of sound insurance and honorable dealings surrounding the institution which all connected with it are jealous to maintain. If a group of underwriters became involved, their associates might come to their aid. This has occurred. There is now a general guaranty fund to protect all contracts issued by its members.

2. The corporation of Lloyd's endeavors to surround the underwriting members with such safeguards as will amply assure their responsibility.

3. The syndicates of underwriters at Lloyd's are composed of men of large resources which are unlimitedly behind their contracts. They are usually managed by skilled underwriters whose careful selection of risks is a further safeguard.

4. Lloyd's is the center of marine underwriting and offers high likelihood of securing ample coverage.

5. Lloyd's underwriters specialize in their own fields, but all fields are represented in the underwriting room, so that unusual contracts may be placed with a minimum of effort.

6. Lloyd's, London, is not restricted in its underwriting to fixed forms of contracts, and hence unusual types of contracts may be negotiated.

7. Each underwriter limits his participation on an individual risk to a very small amount.

On the other side the following arguments may be noted:

1. There is provision for the operation of these underwriters in only one of the United States, and hence the contract must generally be negotiated and enforced abroad[1] or, at least, not in the state of the insured's residence.

2. In event of a dispute the contract must, theoretically, be enforced against each underwriter, though usually a judgment against one is accepted by all.

3. Many of the contracts written appear highly speculative, though there seems to be a certain degree of regularity about these unusual risks when taken in the mass.

Where the advantage of affiliation with Lloyd's, London, is not present, the following further points should be noted:

1. The security of the organization depends entirely on the individuals who compose it, as to both financial responsibility and integrity.

2. It may be found that there is considerable "window dressing" in its personnel and that the important members have narrowly limited their liability.

3. Owing to the individual nature of their contracts, they are not susceptible of careful governmental regulation and have not the discipline of the London organization to replace it.

Regardless of the price at which insurance is offered, the person dealing with such an association should "proceed with caution." Owing to the careful supervision of its underwriters by the "committee," this caution need not, however, be observed in dealing with underwriters at Lloyd's, London.

Stock Corporation.—The stock corporation is the modern organization for the conduct of business enterprises on a large scale and is, therefore, the present successor in the United States of the individual underwriter, whether operating on his own

[1] Several states provide for surplus-line brokers who may place insurance in unauthorized carriers and such business, when the provisions of law are complied with by the broker, is not illegal. But there is no machinery for enforcing the contract in this country.

account or through a Lloyds Association. Its strength and weakness may be seen from the following discussion:

The principle of mass stability assumes that the individual hazards composing the mass are completly independent of each other. If, for example, all the risks of fire assumed by a carrier were concentrated in a single city, a single conflagration might render payable the entire amount assumed by them. Clearly this would be too severe a strain even for a very strong company and it is, therefore, important that there be a geographical distribution of the risks assumed. A corporation cannot do business at a distance from its head office without representatives at distant locations to act for it. Acceptable business does not usually come to it, unless, as in the case of Lloyd's, London, it has through the years (centuries in fact) established itself as the world market or center for its business. Consequently, the corporation must do business through agents, and agents always have to be paid.

The average individual businessman or householder feels himself entirely incompetent to solve the various insurance problems that may come to him and is prone to rely on his friends who may be in the business as agents or brokers for advice, both as respects amount and kinds of insurance to be carried and the companies with which it is to be placed. This places an enormous power in the hands of brokers and agents in the distribution of the business as between companies.

Considering the fire risk as an example for the illustration of principles that apply to other kinds of risk as well, it may be noted that in New York, Chicago, Detroit, in fact in all our big cities, there is a tremendous concentration of valuable goods subject to risk of loss in a single conflagration. As a protection to its business as a whole, each company must restrict the total amount of risk it will assume in any such district to such an amount as, if the conflagration should take place, would be within the amount of its surplus funds. Consequently, there is always demand in the congested-value centers for additional underwriting capacity, and new companies are promoted to respond to that demand.

But all companies wish to spread their operations as widely as may be in order to avoid too much influence from the partic-

ular forces at work in individual localities. Hence, they tend to seek business away from the congested-value centers also. Here the underwriting capacity available far exceeds the need, and competition is exceedingly keen for a share of this business. Since the business is controlled largely by individuals on grounds of friendship and other personal influences, the competition between companies tends to be primarily a competition for the services as agents of those controlling the largest amount of business. And the agents through associations have acted together to establish the most favorable conditions for themselves. Though the simile will be objected to from many quarters on the ground that the business of an insurance agent is a profession and membership in agent's associations is not enforced, yet the situation is not unlike the conflict of interest between employers on the one hand and labor unions on the other. It is not, however, marked with violence. The result has been a steady increase in expense, since the company can secure more business by increasing commissions than by lowering rates. The companies have endeavored to regulate such matters from time to time by gentlemen's agreements among themselves. It is always hard to preserve such agreements when the economic interests of some of those participating are apparently restricted. But it is doubly so when it is comparatively easy for a new interest to come in and, unrestrained by any such agreement, to compete against all.[1]

Though these arguments are stated in general terms, they apply with full force only to those types of insurance carriers which seek business through local agents paid on a commission basis. This is the method of the stock corporations[2] and the arguments apply with full force to them. If the agent as a middle man can be eliminated and as good a selection and distri-

[1] As this argument is phrased, it applies to fire and casualty insurance rather than life insurance. The law of New York places limitations on commission scales, and most large life-insurance companies follow these limitations. Among the younger companies of the West and South competition still tends to raise commission scales, though reserve requirements and the need of meeting competitively the net costs of the large old companies tends to hold them down. The agents' organizations in the life-insurance field also place less emphasis on the defense of commissions.

[2] This point is more fully discussed in Chap. XIX.

bution of risks secured, the selling expense may be much reduced with a consequent lowering of charges to the insured. Therefore, as compared with those types of carriers which are able to do business with the public directly, the stock companies are at a disadvantage in this respect.

The advantages claimed for insurance in a stock corporation are as follows:

1. The cost of insurance is definite. The premium rate is fixed and is not subject to increase by assessment or decrease by dividend. The insured, therefore, knows exactly what he may count on.[1]

2. The capital and surplus are a guarantee of the fulfillment of the contract.

3. The corporation will have a good business organization which will presumably so conduct the business as continually to keep it sound, since the stockholders who control it must bear the loss of their investment if it fail.

4. The wide scope of its operations will further tend to safeguard the insurance.

5. There will be a businesslike handling of losses and claims and other service features are offered.

The competitors of this form of carrier make the following counterclaims:

1. That the cost of its insurance is inordinately high, owing to its agency methods and the conditions described above, and that the competitor's form of organization does not involve these expensive agency relations.

2. That their service is quite as businesslike as that of the stock carriers.

3. That dividends on stock are a needless charge in the cost of the insurance. (These represent so small an item to an individual policyholder that the appeal of the argument lies in its implication rather than in the fact of increase in cost.)

4. That the list of failures of stock companies is as long as of other types or longer, proving that this form of organization does not necessarily guarantee sound management.

[1] As the proposal for retrospective experience rating for workmen's compensation insurance becomes generally adopted, this claim will not be true of that field. Some stock companies now issue participating policies in

5. That an equally good spread of business may be obtained by the particular type of organization advancing the argument, without involving the expense with which the stock companies are burdened.

In short, the attack on this plan of operations centers on cost and particularly on the sales cost, it being alleged that the agent does not earn his remuneration by service and that the field is overorganized. Against this, stock-company advocates present the counterclaims that the agent is the only middleman between company and policyholder and that the selling costs are less than in the merchandising of most commodities and services.

Assessment Mutual.—Associations collecting assessments after the loss, or maintaining only a minimum loss fund and collecting periodical assessments, depend for the liquidation of their losses on the ability of their members to meet assessments. If, through a conflagration or an epidemic, any considerable number became claimants, it would be most difficult to collect at the time when most would be required. Important as it is to all types of insurance carriers to keep the assumption of risk in particular localities or groups within reasonable limits, it is vitally necessary that the risks of this type of carrier be isolated.

Its chief advantage is low cost of conducting its operations, a result of the simplicity of its organization. Hence, to be successful it must so conduct its affairs that its organization may remain simple. If it were to attempt risks of a considerable variety in degree of hazard, it would find it necessary to graduate its assessments according to the several degrees of risk, a problem calling for high skill, broad experience, and a correspondingly complex organization. Further, the knowledge among the membership that all were not assessed alike would raise with each member the question of the justice of his own assessment. Dissatisfaction would result, and a reluctance to pay which might be fatal to the organization. Hence, risks assumed by it must be homogeneous, both in type and degree of hazard.

Since the assessment is made after the loss, the question may arise with each one assessed whether the loss has been fairly

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fields other than life insurance. Many stock life-insurance companies have for years issued participating policies.

settled or whether the company has been imposed upon. On his conclusion in this respect depends his readiness to pay. If the victim is his friend and neighbor, an element of good will is added which may overcome doubt as to the justness of the assessment. If those who settled the loss are his friends and neighbors, they will probably command his confidence.

From the above discussion it will be apparent why this type of organization has been most successful in insuring against loss by fire of the houses or barns of farmers residing within a reasonable distance of one another. The risks are approximately alike in kind and degree. There is practically no conflagration hazard. Since everybody knows everybody else in the association, the moral hazard is reduced to a minimum. For one is reluctant to try to cheat his neighbors. Even if willing to try it, the chance of being found out is too great. The cost is reduced almost to the pure loss cost, the expense is so small. Only an unusual run of losses, or severe depression in the neighborhood rendering members unable to pay, has caused serious trouble.

When these same associations have attempted to operate over a wider area, such as a state, or to take in business property, they have usually failed because of inability to control the moral hazard.

They have also often failed in furnishing insurance against losses due to hail. Single hail storms have seriously damaged large areas and resulted in a type of loss with which these associations cannot cope.

This type of carrier has been very successful in the field of personal-accident insurance when confining its operations to a homogeneous group of risks, *e.g.*, traveling salesmen, auditors, and the like. They have entirely failed in the field of life insurance. Since the risk of death increases with age, they could have a homogeneous group only by limiting themselves to people of the same age. Even here, as the age of the group increases, assessments increase in frequency or amount, or both. This tends to disgust the membership and cause healthy lives to withdraw and insure elsewhere, further increasing the cost, until the organization ultimately fails. On the other hand, when there is some other force, such as a common employment, which tends to keep the age of the group fairly constant and

which makes the payment of assessments to some extent a matter of sentiment, they have often been successful.

This discussion may be summarized by saying that the chief advantage of assessment mutuals is low cost due to elimination of overhead, and that the price of that advantage is restriction of operations to such simple conditions as the organization is competent to deal with.

Advance-premium Mutual Corporations.—The comparative position of mutual and stock companies differs considerably with the kind of insurance written. In the field of life insurance, for example, both types do business through agents paid by commission. In some other fields, likewise, the business is procured through agents working on commission,[1] though, in many of the best of such organizations, the field representatives are paid a salary, and other means are used to cement the policyholder direct to the company, rather than provide indirect contact through brokers and agents who are more or less independent business men. Where this can be done, there is a saving in sales expense.

The advantages claimed for this type of carrier are

1. Lower net cost:

   a. Because of policyholder control, and operation solely in the interest of the policyholders.
   b. By elimination of charges for dividends on stock.
   c. By elimination or reduction of commissions to agents.

2. Better service:

   a. Because more responsive to wishes of policyholders.
   b. Because service to policyholders being the sole cause of their organization there is no conflicting interest.

3. Greater financial strength because there is more margin in the rates than in those charged by stock corporations. These mutuals usually charge the same rates or even higher ones than

[1] The practice in mutual companies in these fields of paying agents by commission is becoming increasingly common. Since the agents recognize that if expenses tend to rise the dividends (their main competitive talking point) will tend to fall, they are content to accept a lower scale than is paid by the nonparticipating companies. This is also true of the agents of stock companies in respect to participating business.

the stock companies. The reduced cost is due to dividends paid to policyholders after the period for which the premium was paid has expired. At the same or higher rates and with lower expenses, larger losses may be met without impairment of protection though dividends may not be paid.

4. A better class of risks can be secured through cooperation of policyholders.

Analyzing these claims in the light of experience one finds they are sustained in some cases but not in others. The facts in opposition should therefore be set forth.

1. The policyholder's control is usually nominal and seldom more than potential. There is great difficulty in bringing a large body of persons together for a corporation meeting. Such meetings are, in the vast majority of cases, composed of but a few persons, each representing a group of interests whose proxies he holds. The management of a mutual corporation is in position to perpetuate itself in power because it has, in its organization, the best means of securing for itself (or if the law prohibits, for its friends) the necessary proxies. Unless the policyholder has a large equity in the company which he cannot withdraw without injury to himself (not generally the case), he will prefer, if he becomes dissatisfied, to drop his insurance and place it elsewhere. The history of this type of company has therefore shown a considerable tendency to nepotism and its corresponding weaknesses.

On the other hand, an opposition ticket is always a potentiality, and the publicity attending a fight on such a subject would seriously injure the company from which the management draws its salaries. This tends to be a check on extravagant tendencies.

This characteristic, therefore, may be a source of strength or weakness depending on the interest that the able policyholders take in the business, and on the wisdom of the management, both of which vary from organization to organization. An able management is not likely to be turned out. On the other hand, rarely, if ever, does a transfer of stock in a well-established stock company result in turning out an able management.

2. The charge for dividends on stock looks important in the aggregate. It sometimes appears large when the rate of dividend

on stock alone is quoted. But when it is borne in mind that the funds representing both capital and surplus serve merely as a guarantee and, not being used as working capital but being invested in interest-bearing securities, earn a large part or all of the dividend on the stock, it will be apparent that the charge on current premiums is usually so small as to be inconsequential.

3. If commissions to agents are eliminated or reduced, there is a corresponding gain, unless some other expense replaces the reduction in commissions and unless the agent or broker performs for his client services equal in value to the excess of his premiums in the stock company over the net cost in the mutual company. Since it is on this point that the mutual company lays its greatest stress, further discussion is appropriate.

It has already been noted that the indifference of the policyholder in placing his insurance gives the agent the whiphand in negotiating with the companies for his remuneration. The argument of stock-company representatives against mutual insurance is the liability of the policyholder to assessment if the company gets into difficulty. To test the merit of this argument, which may either point out a danger or merely be a bugaboo to frighten the thoughtless, the policyholder must carefully study the company. If he does so and is satisfied that the danger of assessment is negligible and the probable savings great, and, therefore, takes his insurance in the mutual company, he does not merely give his insurance to the mutual's representative as he had to a broker. He joins the company. When the policy expires, if his dividend corresponds to his expectation, he is ready to renew *with that company.* His renewal can often be secured by correspondence. In a careful investigation in a large mutual company writing workmen's compensation insurance, it was found that the cost of securing a new policyholder was approximately that of a stock company, but that the cost of securing its renewal orders averaged about 90 per cent less. When the mutual company does not have the assessment clause in its policy, the incentive to a thorough investigation of the company by the policyholder, which existed in the former case, is removed. He, therefore, is not likely to become so cemented to the company, to regard it with pride as *his* company. If another proposal is put to him that looks as attractive, or more so, he is

less likely to take it up with *his* company before acting. It will require a more constant alertness to retain business. Thus the expense is likely to be greater. When the mutual operates through agents and brokers, there is no reason to expect that renewal expense will be lower than initial expense, unless there is a substantial equity which serves to hold the policyholder as in life insurance.

Because of prospective lower cost to policyholders through dividends, it is sometimes easier for an agent or broker to sell a policy in a mutual than in a stock company, and the agent may be willing to sell on a lower scale of commission. The mutual companies that remunerate their agents on the commission basis do usually pay a lower commission, both first year and renewal, than is paid by the competing stock companies.

In the field of life insurance a different situation is found, since the plan of remunerating agents is the same for both types of carriers, though, rates for nonparticipating insurance being lower and policies therefore easier to sell, the commission scales are lower and the selling cost less. The stock company offers insurance at a fixed rate; the mutual company quotes a higher initial rate and holds out a prospect of dividends which will bring the net cost to a lower point in the long run. Assuming equal efficiency in management, the results will depend in part on whether the mortality actually experienced by the mutual company equals, exceeds, or falls below that anticipated by the stock company in making its rate. In general, the trend of mortality in recent years has been toward a lower rate.[1] If this continues, the policyholder in the mutual company will obtain the benefit of it. The relative cost will also depend on whether the rate of interest earned by the mutual company on its investment equals, falls short of, or exceeds that assumed by the stock company in making its rate. Here the ground for prediction is none too sure, for since the First World War the trend of inter-

[1] The fall in the rate of interest in recent years has forced reduction in dividend rates on existing policies with some disappointment to their holders and a less favorable relation to what nonparticipating insurance would have cost. But companies are finding it necessary to base nonparticipating rates on new policies on lower interest assumptions and thus increase them. As conditions become stabilized, the old relation seems likely to be restored.

est rates has been downward. However, the stock company must adopt a reasonably conservative basis lest its own safety be endangered. There are other factors which enter into the problem, but those mentioned are the most important.

4. Whether or not there is better service depends on the interest taken by the policyholders, the ideals of the organization, and its personnel. The factory mutual fire-insurance companies are concerned with fire-prevention engineering first and with insurance second. They set the highest standards of construction and maintenance as prerequisites to membership and maintain a finely trained engineering and inspection staff. The competing stock companies have formed the Factory Insurance Association to meet them, but this organization has not as yet the long record of service of the senior group of factory mutual-insurance companies.

On the other hand, there are mutual companies whose service in preventive work and in other respects has been far below that of some of the far-sighted stock companies which have recognized that such service pays.

5. The claim of greater strength through larger premiums is perhaps valid but tends to offset the argument on costs since this strength becomes available only by omitting or reducing dividends.

6. The claim that the mutual companies get better risks than the stock companies can probably be maintained by some companies, but not by all. Where the agent, as with the stock company, is an independent businessman whose services are sought by other companies, he is in position to bring pressure to bear on his company for acceptance of dubious risks. Since his commission is based on premiums paid to the company, there is an incentive in that fact for him to do so, as well as in the desire to please his client who may give him more business. Unless the mutual company does business through agents on commissions, it is not open to this attack.

If the policyholders take an interest in the company and realize that reduction in expense by larger volume of business and improvement in the loss experience by better selection of risks will increase their dividends, they are likely to recommend new risks and to be careful in their recommendation. This

gain, however, is often too small and remote to be much of an incentive. If the policyholders do not take such an interest, the selection of risks depends wholly on the management. If the desire to increase the size of the company, in order to reduce the proportion of premiums required for expenses, becomes dominant, a poor or mediocre selection of business may result.

Where the solicitor is employed on a salary or a low commission scale, it does not pay to go after the smaller risks. Insurance under one policy covering a large plant (*e.g.*, for workmen's compensation insurance) can be administered more economically than insurance covering smaller risks to yield the same aggregate premium. Therefore, many mutual companies tend to seek the larger risks primarily. In the field of workmen's compensation insurance, at least, there is evidence that the large risks tend to produce a better experience than the small ones.

There are, of course, many small risks needing protection in all fields of insurance. These tend to gravitate to the stock companies which, through local agencies, bring their services to their doors. From the social point of view it is important that they be able to secure protection. It would be unfortunate if there were not proprietary companies willing to assume their risks. Even with the severest competition between stock and mutual for large risks, there seems to be no likelihood of the stock companies being so reduced in number as to cause concern on this account.

Reciprocal Exchange.—There is as great variability in the reciprocal exchange as there is in the mutual corporation. Its chief sales argument is reduction in cost through eliminating commission expense and simplification of management operations. Sometimes these ends are realized in practice, sometimes they are not.

Many exchanges are adjuncts to trade organizations, automobile clubs, and the like, and are really conducted by the advisory board in the interests of the policyholders. In such exchanges the attorney in fact is usually subject to the careful control of the advisory committee, which in some cases may substitute a new attorney in fact.

On the other hand, some exchanges are organized by the high-pressure-salesman type of speculators who wish to control an

insurance enterprise but lack the capital to organize a stock company which will comply with the law, and cannot interest enough persons at the start to operate a mutual or, if they could, fear the probable loss of control. To this type the reciprocal exchange offers a ready vehicle. No responsibility attaches to the attorney for losses if the funds of the exchange prove inadequate. If he can get a core of business on which to start, he can sell widely with no one to control his administration or underwriting, provided he stays within the law. He can provide in his power of attorney for such commission as he thinks his prospects will stand for, and may so word the arrangements that the members' accounts are charged with taxes and sundry other expenses. He may continue for some time on a rising tide of business based on low rates, before the results of extravagance reveal themselves, by which time he may be in another business. A corporation as the attorney in fact may be of assistance in such operations. Unfortunately, such things have taken place, and heavy losses to policyholders and claimants have resulted. This, however, is an abuse of the system rather than an inherent evil.

It is important for the prospective patron of such an exchange to examine carefully the power of attorney and the plan of organization of the exchange, as well as the record of the attorney himself as to both ability and integrity, for much power is to be placed in his hands, for the proper exercise of which only his own character and ability and his surety bond stand as guarantees.[1]

The statutory authorization of the issuance of nonassessable policies by mutual corporations and reciprocal exchanges and the general adoption of that form, at least by mutual corporations; the issuance of participating policies by stock companies; the ownership in the case of several large mutual corporations of stock companies writing other kinds of insurance which their policyholders may need; the adoption by reciprocal exchanges of dividend formulas patterned after those of competing mutual companies and state funds; retrospective rating plans which give rate adjustments, scarcely distinguishable from dividends,

[1] The competitive arguments for and against state insurance and savings-bank life insurance, insofar as they come into competition with insurance with other types of carriers, have been presented in Chap. XVII.

to holders of nonparticipating policies; the provision for advisory and even of full-powered boards of policyholder-directors of state funds—these developments of the last two or three decades indicate rather clearly that evolutionary change of form under the stress of competitive living is not limited to the realm of natural living organisms. In this evolutionary process, lines of demarcation between types, once sharp and clear, tend to become blurred. Without consideration of historical background sometimes the distinctions seem meaningless.

Distribution of Business by Type of Carrier. *Life Insurance.*—The total volume of legal-reserve life insurance in force, as of Dec. 31, 1944, by companies admitted to do business in New York, was $120,788,801,964. Of this 81 per cent was in mutual companies and 19 per cent was in stock companies. In addition, there was $4,635,911,869 in fraternal benefit societies. Most of the stronger companies are admitted to New York, but the gross total figures for the United States as a whole will considerably exceed these. The proportions are fairly representative.[1]

Most of the earlier life-insurance companies in the United States started as mutual companies. As some of the older proprietary companies so grew in size that the capital was very small relative to total assets and as abuses of the proprietary control were found in the investigation of 1906, the movement began to mutualize them. There are more stock life-insurance companies than mutual, but the largest are mutual. This, rather than a special appeal of mutual insurance, causes the preponderance of mutual companies in the life-insurance field.

Fire and Marine Insurance.—Since the reports do not give the risks in force for fire and casualty insurance, it is necessary to use premiums for this comparison. The total premiums on insurance issued in 1944, by fire and marine carriers admitted to do business in New York, were $1,275,106,675. Of this 88 per cent was by stock companies, 12 per cent by mutual companies including advance-premium cooperatives. Lloyd's and reciprocal exchanges wrote $6,019,364, a substantial figure in itself but only 0.5 per cent of the total for all classes of carriers.[2] Coopera-

[1] Advance Printing of Principal Statistical Tables from *New York Insurance Report,* 1945, pp. 40, 161.

[2] *Ibid.,* pp. 70–81.

tive town and county associations total net assessments of $2,532,351[1] or less than 0.2 per cent of the total. However, such companies being strictly local and confined to fire insurance, this figure should be compared with the fire-insurance business of the other organizations in New York state alone to make a proper comparison. This was $85,218,826.[2] Thus the cooperative local mutuals wrote about 3.0 per cent of the total fire premiums of the state. As these cooperatives take only small risks, their proportion of the total number of risks is much larger.

Casualty and Miscellaneous.—Of a total volume of $1,284,577,099 of premiums received by casualty and miscellaneous companies admitted to New York, 74 per cent was in stock companies and 26 per cent in mutual companies.[3] There are no reciprocal exchanges in these fields in New York. In some of the other states the exchanges write a considerable proportion of the automobile-insurance business.

The business of the mutual companies is largely workmen's compensation insurance, automobile insurance, and a small amount of other liability insurance.

Of the total workmen's-compensation-insurance earned premiums of $441,873,474 the State Insurance Fund had $34,191,799,[4] mutual companies $151,642,082, and stock companies the remainder. Thus the mutual companies had 34 per cent, the State Fund 8 per cent, and the stock companies 58 per cent. The mutual companies had 19 per cent of the automobile-liability business.[5]

It should be noted that the state fund does business only in New York. Its writings were 28 per cent of the total New York premiums.

The premiums on individual workmen's compensation risks are large. The insured are business enterprises seeking to keep operating costs as low as possible. Hence the possible saving of mutual insurance has an appeal that is lacking in other casualty lines. Most of the mutual casualty companies began as

[1] *Ibid.*, p. 127.
[2] *Ibid.*, p. 107.
[3] *Ibid.*, pp. 138–142.
[4] After adjustment to stock-company level of rates.
[5] *New York Insurance Report*, 1945, Vol. III, Table 9.

workmen's compensation carriers. As the increased demand came for automobile insurance they naturally spread to that field. In it also the premium to the individual insured is often relatively higher than on the other insurance he carries.

SUMMARY

Each one of the types of insurance organizations in the field has its peculiar strong and weak points. No one type can be unqualifiedly approved as best, or condemned as in no case worthy of confidence. In all cases, the important considerations are the standing and reputation of the particular concerns. Price should be a secondary consideration. If any part of the practices that involve cost can be dispensed with, there is a corresponding saving. The prospective policyholder, seeking the saving by eliminating broker or agent, must himself assume the responsibility of determining the standing of the company and of carrying on negotiations with its representatives.

References

See those given for Chap. XVI.

Part IV

THE INSURANCE MARKET AND THE PROBLEMS OF THE INSURANCE CARRIER

INTRODUCTION TO PART IV

One unfortunate effect of the statutory and practical separation of the insurance business into distinct fields is the lack of appreciation of those engaged in one field that the problems of that field have their correlatives in the others. The essential unity of insurance principles is lost to sight and, instead, there comes subconsciously the impression that the insurance business is not one but several. This attitude has tended to further the popular impression of extreme complexity of the business, generally to its detriment.

Although there are vast differences in the details of the problems presented to the insurance carriers in the different fields and although these problems take on different aspects according to the nature of the carrier's organization, they do relate to things of the same nature. Their correct solution is governed by the same general principles.

It is the purpose of Part IV to outline these essential problems and the general principles governing them, as well as the more usual practical solutions of general application. Special adaptations of general principles and modification of corresponding practices are necessary to meet the variation in conditions in a particular field of risk bearing from those common to most kinds of business or variation due to the nature of the carrier. Much of such detail must be left to writers devoting their attention to special fields. In some cases, on reflection upon what has been said in earlier chapters regarding policy forms in different fields of insurance and the characteristics of the several types of carriers, the reader will recognize the nature of such adaptations. He

will, however, be well advised, in case of doubt, to consult the writings in the special field.

CHAPTER XIX

THE INSURANCE MARKET

CARRIER'S SALES ORGANIZATIONS

Carriers' Need of Volume and Spread of Risks.—It will be recalled that the insurance business in all its branches rests upon the law of large numbers, and that the stability of the rate of loss increases with increase in the number of individuals subject to the same risk. Therefore, the stability of the insurance-carrier's experience will increase with an increase in the volume of its transactions, and consequently it is to the interest of all carriers to seek as large a volume of business as the managers feel they can properly handle. There are also other cogent reasons why the managers of insurance carriers seek an increasing volume of business. In the case of a stock corporation every increase in profitable business means larger aggregate profits for stockholders. Further, whether justified or not when applied to businesses, there is a popular impression, drawn from observation of natural organisms, that there is a natural law of growth and decline under which, when growth ceases, a decline inevitably sets in and ultimately brings decadence and death. Consequently, there is a popular mistrust of any business that is not showing "progress," and even managers of mutual enterprises feel they must satisfy this popular test.

Not only is a reasonably large aggregate volume of business necessary for the adequate operation of an insurance carrier, but likewise a reasonably wide spread. It is fundamental to the operation of the law of large numbers that the individuals' risks be independent, that is, that the occurrence of the event insured against in one case shall not change the probability of its occurrence in another. In contiguous risks this is usually not true. A fire in one house endangers that next door. One person with tuberculosis endangers those with whom he comes in contact. Too great concentration of risk becomes dangerous.

If, for example, a fire-insurance company confined its operations to a single city, it might find its liabilities so great in the event of a conflagration that it could not possibly meet them. In fact, the early underwriters underestimated this possibility, and many of the companies were so destroyed. A carrier writing workmen's compensation insurance in a single industry or region might find that a change in economic conditions which increased the accident hazard produced a serious problem for it, or that a shutdown of the plants of most of its insured would so cut down its business as to make its expense charges an excessive proportion of its income. Such adverse fluctuations are not so likely to occur if the business is more widely spread in area, or over a large number of industries. But the natural working of economic forces, Emerson's mouse-trap assertion to the contrary notwithstanding, does not bring the desired volume and spread. It must be sought.

Sales Organizations Necessary.—There are instances of mutual carriers which have grown to large proportions through the recommendation of satisfied policyholders to their friends. But these policyholders constitute in such cases a selling force, and they are usually constantly urged to this activity by letters from the management, not infrequently accompanied by offers of prizes and other special inducements. But these cases are relatively rare. Most insurance carriers find a well-organized sales staff essential. This is especially true where a stock corporation attempts to secure risks located in other communities than that in which its head office is located. Although one may order overalls or even pianos from the catalogue of a mail-order house, one is not likely so to order insurance unless one's risk is so unusual in kind or degree that it is not sought by local representatives in the neighborhood. Persons seeking insurance for such reasons are so apt to be subject to high moral hazard that few managers are willing to take the chance, though there is one American life-insurance company that does business exclusively by mail, one British life-insurance company that operates without agents, and certain state funds that do business only over the counter.[1]

[1] It is recommended that the student review what was said in Chap. XVII on this point.

Sales Organizations Differ by Type of Carrier.—Although nearly every insurance carrier has some sort of sales organization, the extent and form of the organization differ notably from one type of carrier to another. In the county mutual fire company, for example, the policyholders themselves seek to interest their neighbors in the venture, and the officers give a part of their time to such work, depending on the size and nature of the territory in which the company operates, the amount of their remuneration, and their estimate of the probability of developing a satisfactory permanent business for themselves.

The factory mutual fire companies, especially those of the New England groups, pay close attention to the elimination of hazard and have traveling inspectors and engineers on the road constantly for that work. Working with and through policyholders, they serve to spread knowledge of their companies and bring in new risks.

In other classes of mutual companies, except those writing life insurance, there are usually more or less elaborate systems of solicitors or agents working out of the home office or from branch offices under supervision of branch-office managers, or other officials of the company in charge of their territory. The most elaborate and characteristic organization, however, is that of the stock corporation. The sales organizations of mutual life-insurance companies, and increasingly of other mutual carriers, are similar to that of the stock corporation.

Functions and Powers of the Insurance Agent. *Life Insurance.*—In life insurance the agent is primarily a salesman equipped with a rate book showing the rates, surrender values, and other features of policies issued by his company, as well as sample policies and application blanks. These correspond, respectively, to the price lists, samples, and order blanks of a merchandise salesman. The agent is expected diligently to canvass his field for his company, usually devoting his entire time to it, and canvassing only the type of persons covered by his instruction. He is paid by a commission on the premiums for policies issued upon applications secured by him. The policy is sent to him for delivery, and his powers are limited to securing the application, delivering the policy, and collecting the premium. He cannot bind the company on the acceptance of risks or the settlement of

losses. This type of agent is found throughout the life-insurance field.

Fire Insurance.—Fire insurance is much more intimately associated with commercial transactions than is life insurance, and there cannot be the delay and uncertainty in regard to the issuance of a fire-insurance policy which the system used by life-insurance companies involves. Consequently the carriers have made provision to meet the needs of the business community by providing local representatives with blank policy forms which they are commissioned to countersign and issue in accordance with instructions sent them from time to time. The fire-insurance agent does not usually devote his entire time to that business but frequently combines it with real estate, banking, or other activities, and usually represents more than one company in order not to be handicapped in covering large risks that may be offered him. He will also usually represent companies doing other kinds of insurance business, and they also supply him with policy forms and authorize him to bind them on contract.

Casualty Insurance.—In most lines of casualty insurance the policies are issued by agents in the same manner as in fire insurance. Indeed the same person is frequently the agent of both fire and casualty companies. Sometimes, notably in the case of personal-accident insurance, the agency is confined to the one company and the one kind of business or is associated with a life-insurance agency. But even in these cases the agents are usually supplied with blank policies which they are authorized to issue.

Marine Insurance.—Inland marine insurance is usually obtainable through fire-insurance agencies. The demand for ocean-marine insurance concentrates at the seaports, and companies writing such insurance are represented at the principal ports by agents with wide powers, not only for accepting risks and issuing policies but also for determining rates and conditions. Such agents, however, rarely do business direct with the public. Ocean-marine-insurance business is done through brokers representing the public dealing with these agents.

Theoretically, agents have only such powers as are delegated them by their commission and instructions and as limited by policy forms. In practice, however, under general legal principles

they have such powers as the public, with the active or tacit consent of the carrier, may reasonably be led to believe they have.[1] This becomes of particular importance when the agent modifies the standard forms in some unauthorized way or otherwise exceeds his written authority in dealing with the public. These agents may, with approval of the company, settle minor losses and assist in the settlement of more serious ones but, in general, a separate type of representative is used for this work. The agent is paid a commission on the premiums on policies issued by him as provided by his contract.

Agency Supervision.—A widespread network of agents requires a separate department or organization within the carrier for their supervision and control. There are three systems of agency organization in the United States and, although one or other of these will be particularly characteristic as the dominant policy of any given carrier, all three will be found in use to some extent by many carriers. These systems are the *general-agency, branch-office,* and *direct-reporting systems.* Although the last is the system best adapted to, and most used by, small organizations operating in limited territory and is, therefore, probably the oldest, the first named is most used by corporations doing business over a wide area because it is best adapted to pioneering extension. In well-organized, closely built-up territory, the branch-office system has recently come into greater vogue. This is particularly true of life-insurance companies and casualty-insurance carriers. In workmen's compensation insurance the carrier promises to serve the employer by safety inspections and by investigation of claims for compensation. It also must audit pay rolls to determine premiums. Under liability policies it also promises claim service which must be prompt to be effective. Sometimes payroll audits are necessary under these policies. Carriers may arrange with independent firms to perform these services, but policyholders are generally better satisfied if they know that the carrier has facilities close at hand. This has led many companies to establish "service" branch offices. It is an easy and natural transition to convert such service offices to branch offices for agency work as well. Only a few mutual companies now use the direct reporting system exclusively.

[1] See Patterson, E. W., "Essentials of Insurance Law," pp. 413–418, especially 416.

General-agency System.—Under the general-agency system, as it usually exists in the United States, contracts are made with individuals to represent the carrier in certain territorial divisions of the country for a fixed term defined in the contract. It is the duty of the general agent to cultivate his territory diligently, and to procure a corps of agents and subagents to represent the carrier in the smaller sections of his field. He may receive business from brokers. He may be a personal producer. His contract provides for remuneration in the form of commissions on the business he develops for the carrier. Sometimes his contract limits the commissions he may pay to subagents; in other cases he has a free hand. He may pay some solicitors on a salary basis. In life insurance he is called upon only to produce the business, *i.e.*, to secure applications for insurance. In other lines, *e.g.*, fire insurance, he may represent the company on rate-making bodies and has wide discretion in accepting or rejecting risks. He may also have charge of loss settlements in his territory. Where his powers are so broad, his remuneration sometimes includes a profit-sharing arrangement based on the results of the business in his territory. This system is more often used by the younger and smaller stock companies.

The services expected of a general agent and the degree of power to bind the carrier vary greatly according to the kind of insurance and the business policy of the carrier. In some cases, particularly in marine insurance, the delegation of power is so full that he reports to the head office only in summary, and it is necessary for state officials examining his carrier also to examine his records and accounts if they are to get a true and complete picture of the carrier's operations and condition. In some cases the general agency is practically the equivalent of a regional branch office, as in the case of a general agency of a fire-insurance company for the entire Pacific coast. In other cases the designation as *general agent* is merely a courtesy title to lend apparent dignity to his position, perhaps give closer contact with the senior officers of the carrier, or make possible payment of a higher scale of commissions. Large regional general agencies frequently represent several carriers and have their own staffs of fieldmen, auditors, and adjusters.

Branch-office System.—Under the branch-office system the field is covered by branch offices each in charge of an officer of the

carrier or a salaried manager. It is an extension of the head office into the field. The powers and duties of branch-office managers differ with the size of their territory and the business policy of their carrier. In many instances they have charge of all business of the carrier, with authority to settle losses and do other work. Most incorporated mutual companies are represented in this way outside the territory adjacent to their home office. The territory of a branch office may be cultivated by salaried men working from this office. This is often the practice of mutual companies other than life-insurance companies. It is the usual practice of stock companies to have local agents in the smaller places paid by commission. The purpose of the branch office is control over the business and convenience in service to and supervision of agents.

Direct-reporting System.—Under the direct-reporting system there is direct contact between the local representative and the head office, without intervention of any general agent or branch office.

In many cases the carrier will make use of all three systems, a part of its territory being on each basis. In any case the general supervision of the business-getting work is in the hands of one or more of the senior officers of the company, usually of vice-presidential rank, with a corps of junior officials to assist him. In a large fire-insurance company, there will often be a vice president in charge of each of the major territorial departments. The junior officials are called *agency superintendents* or *agency supervisors*.

Basis of Remuneration.—Among the stock companies local agents are almost universally paid by a commission on the business they procure. Sometimes there is a contingent additional commission based on the loss ratio of their business. Although the latter appears to the uninitiated as a highly desirable thing from the carrier point of view, there is far from unanimity among the carriers in regard to the practice, particularly as nearly every agent represents two or more carriers and will be tempted, if he sees his loss ratio with one of them going adversely, to turn his good risks to another in the hope of securing a "contingent" from the latter. This naturally creates friction between the carriers and has had a tendency to raise the general level of com-

missions.[1] There are other pros and cons with regard to the system which cannot well be elaborated in this brief exposition.

Among the mutual carriers writing property and third-party insurance the local representatives are often paid exclusively on a salary basis, though mutuals are tending also to use the commission system.

Special Agent.—To those who have had any acquaintance with formulating and carrying through policies for extensive organizations, it will be obvious that it is almost, if not quite, impossible to secure and maintain, by means of correspondence alone, adequate control of, and continuous enthusiastic activity among, a widely scattered group. This is true even when the territory is not very wide, as within the territory of a state or district general agent or manager.

In the life-insurance business the usual means of securing these desiderata are periodic conventions by districts, at which one or more of the officers of the company are present. There are also national conventions which those producing a given volume of business are privileged to attend. This is a satisfactory method in this field where the agent usually works exclusively for one carrier. But in the case of the fire, casualty, and allied lines it is hardly practicable.

In these branches of the business contact between local agents and head, branch, or general-agency offices, is secured through *special agents* also called *fieldmen.* The special agent is a traveling representative usually assigned to a particular territory. It is his duty to see that his company is adequately represented in the communities in his territory. If there is a vacancy, he must seek a suitable person or firm to fill it and give instruction in the company's plans and methods. He must periodically visit the agencies in his territory and keep the good will of his agents. In the fire-insurance business in particular, where several carriers are frequently represented by the same firm, often a real-estate office, he must see that his carrier gets a fair share of the business and is not regarded by the agent as the dumping ground for the risks that the others do not want. He must instruct his agents in business-getting methods and cooperate in securing difficult

[1] See Wandel, William H., "The Control of Competition in Fire Insurance," pp. 85–88.

lines. If the agency is not satisfactory and cannot be made so, he must close it up and procure a new representative. He must periodically inspect the records and accounts of the agency and see that proper records are kept and business correctly reported. If the agent is not prompt in his accounting, he must ascertain the reason and correct it. If he is slow in remitting balances, the special agent must arrange to correct this difficulty, if possible, or "lift" the agency.

If there have been unsatisfactory losses in the territory, he must seek the cause and endeavor to protect his company's interests in this respect; also, if the case requires, he will assist in adjustment work, though this work now is usually performed by a different set of representatives reporting to another department. Formerly a considerable amount of adjusting work was an important part of the special agent's functions and, in fire insurance, he was often delegated on a committee with special agents for three or four other companies to "rate" a community. This latter function, has now been taken over by special rating organizations.

The duties of the special agent require a broad understanding both of the business as a whole and of his company's plans and practices in particular. Naturally, therefore, this position leads toward general executive work in the producing and underwriting departments of the company.

Agents and Rate Making.—Local agents generally have no rate-making powers but, in many lines of business, general agents have large powers of rate making through representing their companies in rate-making organizations. As noted above, special agents have also had a large part in the making of rates when sparser population and more restricted means of communication prevented the degree of centralization now obtaining. When the local agent is in competition with "nonboard" or "cut-rate" companies, he usually puts pressure through his supervising specials on the representatives of his companies to secure "relief," *i.e.*, authority to meet such rate competition.

Dual Loyalty of Agents.—Theoretically, the agent is the representative of his company charged with responsibility for scrupulously conserving its interests. In that capacity he owes the highest loyalty. Practically, however, in many cases his representation of the company is only incidental to many other

interests, as a real-estate dealer or banker, merchant, or other type of businessman. And his remuneration by the company depends on the business he produces for it. He can produce such business only by satisfying the people of his community that their interests are ever present in his mind. To retain the good will of large customers who have been or may be solicited by brokers, alert agents often offer as full service as do the brokers.[1] They cannot, as agents, offer so wide a choice of carriers as the broker, for they must confine themselves to the companies they represent. They may, however, act as brokers in placing risks with other companies. In the larger centers, the *broker-agent* is becoming increasingly common. If their interests conflict with those of his company he must decide between them, with the realization that he expects to continue to live and do business in that community. Naturally, therefore, there is great incentive to place the policyholders' interests above those of the company. But if he is grossly unfair to the company and his agency is lifted, he may not again be able to get a satisfactory connection, for despite the keenness of competition, the companies will not, in general, employ an agent who is known to have wronged another company. The company that accepted him might be the next victim.

The companies recognize this difficulty of the agent and go as far as they can to meet his wishes. The status of the agent as an independent proprietor is also generally recognized by the companies, and the recognition of that status seems to be the core of the so-called "American agency system." This recognition goes to the point of recognizing the *expiration list* of the agency as the private property of the agent to which, on cancellation of the agency, the agent, and not the company, is entitled. By expiration list, sometimes called *expirations* for short, is meant the record of names and addresses of present policyholders and the dates of expiration of their policies. The possessor of this list knows when to solicit renewals. Although the companies have in their home-office records the same data, it is not considered ethical to supply these to a new agent who may represent the company. Because Life-insurance policies are lifetime contracts and because the insured loses by canceling his policy and transfer-

[1] See pp. 345–349.

ring to a new company, the above observations do not apply to that business.[1] On the other hand, the agent's renewal commissions on life insurance often continue after he leaves the company in order to secure his interest in payment of renewal premiums.

Accounting Control.—Where, as in fire insurance and most casualty lines, the agent is supplied with policies bearing facsimile signatures of the company officers, and valid on his countersignature, it is necessary for the company to develop adequate accounting control to know what risks have been accepted for them and to prevent unscrupulous agents from defrauding them. The usual practice is for the company to number consecutively the forms supplied and to require the agent to send in, on a prepared form, known as a *daily report*, a copy of the written part of each policy issued by his office and of all endorsements upon it. The forms are drawn up to register with the policy so that the "daily" can be made up as a carbon copy. The numbered forms are registered at the head office as supplied to the agent and must be accounted for consecutively.

The agent is required to render an *account current* at the end of each month covering the business of that month.[2] In this account, the policies issued during the month must be listed consecutively, and there must be suitable vouchers for all expenditures. One line is devoted to each policy, and particulars are given which are checked against the daily reports on file. In the account the agent is debited with the premium on each policy and credited with the commission; in like manner the company is debited, the agent credited, with all refunds of premiums on account of canceled policies, including those "not taken." On these the company is credited with return commissions. The usual practice is to allow the agent 2 months in which to make remittance for the balance shown by his account.

[1] "Twisting," *i.e.*, persuading a policyholder to drop an existing policy in one company to replace it in another, is considered unethical, and the companies as a group earnestly fight it. In many states misrepresentation of the terms of a contract, either the existing or proposed contract (the usual procedure of the "twister"), is prohibited by law. It is, however, difficult in practice to procure convictions even when the law goes so far as to prohibit "incomplete comparisons."

[2] See reproduction of an account current used in fire insurance in Appendix XX.

Competitive Expense.—The organization indicated above entails no little expense for supervision, though this is much less than the commissions paid.

As expense is the chief point of attack on the system of conducting the business by private stock companies, it is well to amplify here what has been already pointed out with regard to competition and commissions. The individual businessman and householder usually gives his insurance business to an agent or broker on the basis of confidence, either because of his standing or from personal friendship. The broker or agent is then in position to bargain for the best terms that he can obtain from the carriers. Unless the carriers are limited by statute as to expense of getting business (which is not often the case), or can reach an agreement among themselves, each carrier must make the best terms it can. The agents have their own state and national organizations, which have forced the carriers to recognize the principle of the "American agency system," and there has been a tendency for the companies to form agreements among themselves to prevent excessive commissions. Under such conditions an unusual amount of power rests in the hands of the carrier that stands out for high commissions. The carrier that is most apt to do this is the newer and less known company, whose coverage is less easy to sell and which therefore has most difficulty in securing agents. As agents, in their own interests, prefer to represent strong reputable companies, these latter are able to maintain a somewhat lower commission scale, but even the strongest company cannot ignore the bids of its weaker competitors. Thus, competition for agents, for which in the last analysis the insuring public is responsible, tends to increase the expense and, correspondingly, the rates of the companies.

BROKERS

Just as a person unfamiliar with the technique of a market, or unable to give careful attention to the details of the conditions of a particular market, or unable to gain direct access to others in a market, will often employ another party to act for him as a broker, so the early traders used brokers to procure their marine insurance. Gradually the broker extended his activities to cover all lines of insurance. In all metropolitan centers are found

large numbers of insurance brokers, and some brokerage firms are nationwide or even international in their scope. The function of the broker is to act for the insured in handling his insurance problems. Although not declining to serve those whose insurance need is limited, the broker specializes in serving those whose insurance needs are large and many-sided, especially large corporations.

A competent broker will study the insurance needs of a business house and make up a complete schedule of the kinds and amounts of insurance to be carried, including in the schedule the fidelity and surety bonds required. He will investigate the physical condition of the plants and properties (often maintaining an engineering department in his office for that purpose), recommend changes to reduce the hazard, and secure the lowest rate. He will keep records of expiration dates and call attention to the need of renewing expiring policies. He will endeavor to keep in touch with inventories and advise as to the expansion and contraction of the amount of insurance covering them. He prepares the most suitable forms to give the most complete coverage on the best terms, with due regard to coinsurance and like conditions, and endeavors to see that the insured keeps within the limits of restrictive clauses in the policy. He places the insurance with companies he considers good and keeps in touch with the condition of the companies so as to advise if he thinks a change should be made. If his client is so unfortunate as to have a loss, he keeps in touch with the adjustment and tries to see that he receives a fair settlement though, in a complicated case, he is not expected to act throughout as the adjuster for the insured. In such a case a special public adjuster may be called in.[1] In short, the broker acts as the expert adviser of his client in regard to his insurance problem.[2]

For all this service the broker neither receives nor asks pay from his client, for the broker is customarily paid a commission on the premium by the company in which he places the business. His commission is not so large as that of an agent who devotes

[1] See Chap. XXII.

[2] To avoid misunderstanding, it should be emphasized that the above refers to *competent* brokers of the highest type. Unfortunately not all conform to this description.

his entire time to his company or divides it between the companies in his office. The broker, who is a free lance and not tied to any single company, must place his business through some agency office unless the carrier maintains a branch office in his locality for the service of brokers. When the business is placed through an agency, the commission paid him comes out of the agent's commission. The agent usually retains an overriding commission, which contributes to the expense of maintaining his office.

Despite the fact that he is paid by the company, the broker, since he is free to place his business with any company, is not the company's agent. He has no contract with any company. For the purpose of placing the business he is the agent of the insured. Knowledge communicated to him by his client is not the knowledge of the company as it would be if communicated directly to the company's agent. Misrepresentation on his part is that of his client. These points should be borne in mind by those procuring insurance through brokers, and the general standing and integrity of the broker should be very carefully scrutinized.

Although the broker is the agent of the insured for procuring the insurance, it does not follow that the insurance company can always safely deal with him as the agent of the insured in other respects in regard to the policy. For example, if the company desired to cancel, a notice of cancellation sent the broker would probably not satisfy the policy requirement of notice to the insured. The powers of the broker to represent his client are only such as his contract with his client gives, or as the public is led with the consent of his client to believe that he has. This sometimes causes no little perplexity to a company representative who may be called upon to cancel a policy. He wishes to retain the broker's good will because of the business he may be expected to give him. Consequently he will be ill advised to serve notice on the broker's client over his head. On the other hand, if he does not procure a valid cancellation, he may be liable to his company for breach of duty as its agent. Usually such a matter is handled practically by requesting the broker to replace the insurance elsewhere and return the policy for cancellation, allowing a little time for this before sending notice to the insured.

Although the broker is the agent of the insured, his relations with the companies are necessarily very close and in some metropolitan centers there are agreements between the companies of a particular type, *e.g.*, stock fire-insurance companies as a group, and the brokers' association that the companies will not have any soliciting agents in that center but will accept business only through brokers, maintaining, however, metropolitan offices for the accommodation of the brokers. Sometimes the same individual will be a broker in the metropolis and a local agent for one or more companies in his suburban home community. In some cases agents for companies doing a single kind of insurance, *e.g.*, life insurance, will also act as brokers in the same place for placing other kinds of insurance for their customers.

With such close relations, the custom has grown up of issuing policies at the request of brokers for their clients without ascertaining whether the broker has an order for such a policy. The policies issued to brokers are not required to be paid for in cash, the companies' metropolitan offices usually carrying accounts with the leading brokers and charging their accounts with policies so delivered, calling for monthly settlements, and usually requiring payment or cancellation within 60 days. This has been made the means of abuse by obtaining free insurance in too great a number of cases, sometimes with the connivance of the broker, sometimes without. For example, if a policy has been issued and charged to a broker it is technically in force and, if a loss occurs, claims may be made, the client ratifying the broker's action and paying the premium. This naturally will always be done where a loss has occurred. If no loss has occurred, the insured may decline to take the policy on the ground that he did not authorize the broker's act. The broker then returns the policy as "not wanted" or "not taken." Recently efforts have been made to obtain a record of brokers who are persistent offenders in this regard, and even to force payment of prorata premiums. Since the funds of the companies arise only from premiums and investment earnings, this abuse of free insurance is obviously at the expense of higher rates to all.

Though the broker is generally the agent of the insured for procuring the insurance, the courts have in some cases held that, where credit has been so extended and policies have been turned

over to the broker to deliver and collect the premiums, the broker thereby becomes the agent of the company for that purpose. In some states there is statutory provision to that effect. Several have gone so far as to provide that any person who solicits applications for insurance, other than his own insurance, shall be deemed an agent of the company.[1] The insured, however, unless assured of the unquestionable integrity of his broker, will do well to make sure that he has the receipt of the company or its authorized agent for all such payments.

INSURANCE BUYERS AND CONSULTANTS

The hazards to which the properties of large enterprises are exposed are many and varied, including physical hazards, exposure to loss from claims for damage under liability laws, and other sources of possible loss. Properly to protect them by insurance is a complex problem for whose correct solution constant alertness and an intimate knowledge of the enterprise and its affairs are essential. Since the passage of workmen's compensation laws with their requirement of insurance, and the development of group life insurance, of group disability insurance including hospitalization benefits, and of retirement plans, personnel departments have also been confronted with insurance problems. In the past, such enterprises have generally turned to large insurance-brokerage houses for assistance and advice and many still do.

It was noted in Part III that the mutual carriers and some reciprocal exchanges strive particularly for the business of such enterprises. These types of carrier have not generally done business with brokers, and as a whole brokers have tended to favor stock-company insurance. The savings in insurance cost represented by the dividends under participating policies are large when the premiums themselves are large, and the managers of these enterprises have had to consider possible advantages in dealing with these carriers. This is particularly so when the carrier, as often in workmen's compensation insurance, bases its dividend wholly or in part on the experience of the individual risk. Sometimes these carriers have offered forms or conditions of coverage, *e.g.*, deductible conditions in fire insurance, which

[1] Patterson, *op. cit.*, p. 34.

the stock companies are unable, because of intercompany agreements, or unwilling to grant. The various competitive arguments and offerings need to be carefully examined and weighed. This takes more time than executives and directors feel they should give and often requires knowledge and experience that they do not possess.

These conditions have led some firms to employ full-time or part-time insurance buyers or consultants. These buyers and consultants have formed an association for consultation and discussion of their common problems and have often invited representatives of all types of carriers, brokers, and other experts to attend their meetings.

The competent buyer should have a knowledge of insurance principles and practices second only to that of a senior executive of an insurance carrier. He should and does constantly study the condition and records of all types of carrier and of individual carriers within each type. He should not neglect state funds and should consider the possible advantage of self-insurance. In this study he should endeavor to put aside all bias and recognize and quickly distinguish prejudiced propaganda. He should constantly study the various forms used, note developing changes and trends, and appraise the value and limitation of various types of policy provision.

If the buyer is a full-time employee, he should and will, if he is competent, be in constant touch with the comptroller and all department heads of his concern so that he will be informed at all times of changes in hazards and exposed values of the enterprise. Only as the enterprise gives him full access to such contacts and records can it expect to get the maximum value from his service. On first undertaking his work he will probably make a critical survey of existing insurance to determine its adequacy in scope of coverage and amount and also to eliminate any overlaps. He will see that proper inventory, appraisal, and other records are kept to facilitate the settlement of claims.

The competent buyer will not hesitate to deal with brokers or local agents but, realizing that his employer through the premium loading pays the commission that the agent or broker receives, he will insist on the service that commission is supposed to pay for. When policies are received, he must carefully inspect them as to

both their printed and their written terms and send memoranda to department heads and others calling attention to conditions and provisions of which they should be aware. If the available forms in the market do not give the exact coverage he feels his employer is entitled to, he should not hesitate to prepare his own and seek carriers to write it.

In short, his job is to get for his employer the best-adapted program of sound insurance the available money will buy and, if the appropriation proposed for the purpose is inadequate, show the advantage of a proper increase. Since his compensation is usually independent of the cost of the insurance, his personal interests are not at all, as with agents and brokers, affected by it. Compensation on the basis of savings in cost is inadvisable because it would have to be on apparent savings, which might not in the long run be real savings.

There are certain sources of information about insurance carriers, their practices, and conditions which are open, not only to professional insurance buyers, but to the public at large. Even the small individual buyer might well use some of them. The professional must keep in constant touch with all.[1]

At the present time federal and state tax laws and their exemption provisions have important bearings on some plans of insurance, particularly employee-benefit plans, and the insurance buyer in his work must give consideration to them.

SUMMARY

Although the subject matter of this chapter cannot be so simply summarized as some of the preceding, the following salient points may be noted:

1. Human nature is such that insurance must be sold, for it is rarely bought.
2. The best interests of all require that each carrier obtain a reasonable spread of business.
3. To do this it must develop a sales organization or agency staff.
4. Agency organizations require close supervision, for which there are three systems, found in varying combinations in nearly all carriers:

[1] In Appendix XXI a brief list of such sources is given.

a. General-agency system.
b. Branch-office system.
c. Direct-reporting system.

5. Some life-insurance and most mutual companies in other fields operate on the branch-office system.

6. Agents are usually paid by commissions on premiums.

7. Fire and casualty carriers usually maintain contact with local agents through a special agent.

8. The agent is often an independent businessman who owes a loyalty to his clients and community, as well as to his company. Sometimes these loyalties come into conflict.

9. Accounting control is maintained by numbered forms, systems of daily reports, and monthly accounts.

10. Any agency organization must recognize the existence of, and be prepared to deal with, brokers who are independent representatives of the insured.

11. The relation between brokers and agents is very close, and the broker is, for some purposes, the agent of the company.

12. The cost of competitive selling is a large part of the cost of furnishing insurance. This is due chiefly to the attitude of the buyers of insurance.

13. Large enterprises often employ insurance buyers and counselors to handle their insurance problems.

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CHAPTER XX

PROBLEM OF RATES

The problem of rates is at once the most important and the most complex and difficult of all that confront the insurance carrier. More than any other it calls for a distinct and different solution for each kind of insurance. For some lines of insurance, *e.g.*, life insurance, fire insurance, workmen's compensation insurance, the record of progress in its solution is voluminous. For some other lines little, if anything, has been published regarding rate-making method. With the possible exception of life insurance, it cannot be said of any line that the theoretical ideal in rate making has been reached. Yet the present methods in all lines are the result of a considerable period of development and the expenditure of time, thought, and effort to make them as good as is now thought practicable.

The first part of this chapter is devoted to an analysis of the problem and the objectives to be sought in its solution. In the second part some comments are made on the practices followed in rate making in the more important branches of the business.

It has already been noted that the monetary consideration for any insurance policy is known as the "premium." In the aggregate, the premiums of any company must provide for two things: the losses which the company may reasonably expect to incur on the business for which those premiums were collected, and the expense involved in carrying out the obligations incident to that business. If the premiums are received in advance of need for loss payment and will earn interest in the meantime, this interest may be used to meet part of the losses and expenses, but, except in the case of life insurance, it is not possible to calculate the other elements with sufficient nicety to permit the interest factor to be considered in the calculation of premiums.

In general, the premium is arrived at by applying to the face of the policy a rate per unit ($100 or $1,000), but there are cases

where a different basis is used.[1] In order to understand the reasons for such units and several other aspects of rate making, it is necessary first to acquire a certain familiarity with the concept of equity in relation to insurance rates, and the special reasons for its great importance in this connection.

GENERAL PRINCIPLES

Concept of Equity.—It is an indispensable quality of insurance rates that, in the long run, they not only must be adequate to meet the needs of the carriers for losses and expenses, but should be equitable as between the several policyholders. This is true, not only because fairness and statute law require it but because, under the action of fundamental economic laws, inequity in rates is a serious source of danger to the carrier. Before elaborating this point it is desirable to consider what is meant by fairness or equity in insurance rates.

The Century dictionary defines equity as "that which is equally right or just to all concerned; equal or impartial justice; fairness; impartiality." But how is this to be applied to insurance rates? In Chap. III, in presenting the application of the law of large numbers to the problem of risk, which underlies the insurance business, an illustration was given of a concern so large that this law operated within its own experience. It was pointed out that the same result might be obtained by utilizing the combined risks of many smaller concerns, if the factors causing loss to each of them were the same and of the same intensity. In that case no one concern entering the pool would receive more in benefit than any other. Even though the railroads were of varying size, no one road would be carrying an unfair load if their contributions to the pool were proportional to their size. But if the conditions of one road were such that losses occured twice as often as with another, with equal contributions to the funds of the pool, that one would in the long run draw twice the indemnity payment of each of the others.

Or, let it be assumed that the roads in the pool are of two groups, or classes, in one of which the losses occur with twice the frequency obtaining in the other; that the numbers in each group are sufficiently large to produce dependable average

[1] See Part II.

results; finally, that the numbers in each group are the same. If the numbers in the less hazardous group are called upon to pay only their own losses, the periodical amounts which they would be called upon to pay would be but two-thirds the amount they would pay if the losses were spread equally over the combined groups. Likewise, if the more hazardous group were in a separate pool, their costs would be one-third greater than under a combined pooling arrangement. It is apparent that the charges under the combined pool unduly favor the more hazardous group and penalize the less hazardous group. Such rates are clearly inequitable under the definition of equity given above.

In general, equity in insurance rates may be defined as that relationship which corresponds to the long-run value of the several risks insured, so that, if a sufficiently large group of like risks to give full play to the law of large numbers were taken in place of each individual risk, the several groups would be charged just enough to pay their own losses and their fair proportion of the general expense of the company.

Although this will serve as a definition of the concept of equity, it will not do as a practical test of actual rates. The practical rule which corresponds to it, and which may fairly replace it, is that the rates an individual is called upon to pay shall be the average value of the risk assumed, as nearly as it can be estimated, plus a fair proportion of the amount required for expense.

Consequence of Inequity in Rates.—Rarely in fact does the general rate level for any carrier show for any considerable time a substantial margin for profit. If, then, rates are not equitably adjusted, one group of policyholders are paying more than the long-run cost of their losses and their proper share of expenses, and another group are paying less. Competition between carriers is exceedingly keen, not only between carriers of different types but also between those of like types. Consequently, there is considerable probability that those paying excessive rates may be able to secure their insurance on more favorable terms elsewhere. If they do so and leave the present carrier in considerable numbers, then, since there is no longer a profit to balance the insufficient rates of the other classes, the carrier whose rates are not equitably adjusted stands to lose, and ultimately may become insolvent. The history of fraternal life insurance well illustrates

this principle. The rates of the several orders were not equitably adjusted according to the ages of the members, and the younger members could not be held in the older orders. Left only with the older and less healthy members, rates had to be raised, or the frequency of assessments increased. This accentuated the difficulty, and resulted in the ultimate failure of several orders.

If, because the total cost to the individual policyholder is still relatively small, as in the case of fire insurance on residences, the insured does not seek insurance elsewhere, the condition is still one of danger to the carrier, since its competitors will seek such business more persistently in order to gain some of the profits from the excessive margin in the rates. This competition usually takes the form of higher commissions or lower rates for the "preferred risks."[1] This competition can be met only by similar action. In either event the margin of profit on such business is correspondingly reduced, and the company again is exposed to excessive loss from the low-rated risks.

Thus, it is in the long run essential to the welfare of the insurance carrier that its rates be as equitably adjusted in their application to individual risks as it is possible to make them. Exact equity is impossible of attainment, for the risks offered for insurance differ from one another by small gradations, some of which cannot be recognized in practice.

In the statutes of several states that have delegated supervision of rate making to the insurance commissioner[2] the criterion that he is directed to apply is that the rates shall be adequate, reasonable, and nondiscriminatory, by the latter term meaning *not unfairly discriminatory*. The reasoning in this section has been addressed to the need of equity which is the absence of unfair discrimination. Taken with what was said earlier, the argument in this chapter seems to sustain this formula as a proper criterion from the point of view of the long-range interests of the carriers as well as of the public.

Problem of Classification.[3]—The first step in proper rate adjustment is classification. It cannot be said that the division

[1] For other reasons why such risks are preferred see p. 377.

[2] See Chap. XXVII.

[3] The term "classification" is used in a dual sense in insurance. It is used to denote a *class* to which risks may be assigned, and also (and more

of the insurance business into several fields or lines of business was the result of the necessity for equitable rates. But certainly such division is the first step toward rate equity, since it is exceedingly difficult to measure relative hazards quantitatively when they are of different natures. When the carrier writes several kinds of insurance, it is customary to conduct the business of each in a separate department or section, though the assets are not kept separate.

But this is only a first step. Within each field or kind of insurance the risks must be more or less carefully classified to associate together those of like degree of hazard. How shall this classification be made? This question cannot be answered with complete satisfaction. No simple rule can be laid down, for the degree of risk, as one passes from case to case, does not increase or change by distinct intervals. Rather, the transition is gradual, almost imperceptible. Classifications, to be workable, must have well-defined boundaries, and difficulty is encountered with borderline cases in insurance as in all other fields where things that differ by small gradually changing intervals must be fitted into an artificial classification system. In insurance practice, the classification must be based on characteristics which are easily recognized and ascertained and which will appeal to the insured as reasonable indicia of differences in hazard. A few instances of practical insurance classification, taken from different branches of insurance, will illustrate both the practices that have been adopted and the difficulties.

Fire Insurance.—In fire insurance the type of construction of the building is the first basis of classification; for example, class A (popularly called "fireproof"), brick, frame, and mill construction. Usually the class rate is further modified by a schedule which analyzes hazards.[1] This schedule may be regarded as an extension of the rough classification to the recognition of

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properly) the *process* of dividing risks among these classes. See also pp. 357, 385.

[1] Because of the expense involved in schedule rating, many small risks are not so rated but take what are known as class or tariff rates. In such cases the classification by type of construction is carried further by considering occupancy. Occupancy is always an item considered in the schedule.

finer divisions. Hence, the basic classification may be broad and include a wide range of hazard. For the purpose of studying experience the practice of the several companies in classification varies widely. In one investigation it was found that in some offices less than 10 classes were provided in the system; in others, there were over 1,000. The National Board of Fire Underwriters has established a standard classification, and progress has been made toward its general adoption.[1]

Marine Insurance.—Attention was called in Chap. VII to the international competition that characterizes marine insurance. Little information is available as to the methods by which rates are made for marine insurance. Indeed it is of record[2] that the entire matter of rates is one of individual judgment in the face of the keenest competition. Under such circumstances details are not made public, and it would appear that classification of risks cannot play a large part in rate making in marine insurance. The underwriter, however, does keep in mind, in deciding on the acceptability of a proposed risk, the type of cargo and its characteristic hazards, the trade and its customs and routes, including ocean currents, stormy seasons, safety of harbors, and landing facilities as well as the physical characteristics of the ship and the record and standing of its owners. Probably more important is the experience record on past business of the broker proposing the contract, for he usually suggests a rate at which he thinks it should be written.

Life Insurance.—Life-insurance companies do not generally attempt to insure all risks at an appropriate rate, but rather confine their activities to the insurance of lives that are at least up to a certain standard. Generally no distinction is made in the treatment of those who can pass.

For each type of policy and age at issue a single uniform rate is quoted. No preference is given those apparently better than average. Some of those below average have been taken at extra

[1] The Federation of Mutual Fire Insurance Companies has its own classification. The whole subject is under study by insurance departments and by the Insurance Executives Association.

[2] *Hearings before Subcommittee on Merchant Marine and Fisheries*, 66th Congress, 1st Session, pp. 204*ff*.

premiums, but those seriously below standard have been rejected.[1]

Under such circumstances a very simple system of classification based on obvious differences in hazard is possible and adequate. From time immemorial it has been recognized that, other things being equal, the probability of death increases with age. Since Halley's investigation of the mortality rates in Breslau, it has been recognized that mortality tables, if properly constructed from suitable data, give a reasonably accurate measure of the mortality rate at each age, and that life-insurance premiums calculated from such a table will be sufficient to assure the contract being fully carried out at a level rate. Hence, the age of the insured is the basis of classification of risks in life insurance for rate making. When the companies undertake the insurance of substandard lives, the risk is estimated in terms of equivalent age mortality, and risks are rated up in nominal age to correspond to the expected mortality.[2]

Workmen's Compensation Insurance.—In no field of insurance has the subject of the proper basis of classification received more careful attention than in that of workmen's compensation. Yet here the system of classification on first sight appears most illogical. The interplay of several forces accounts for this.

1. The workmen's-compensation-insurance business grew out of the employers'-liability business, which had a system of classification that appears to have grown up under the stress of competitive bargaining without much study of proper principles of classification. With this the business world was more or less acquainted, and it was adopted in the first instance. But having been adopted, it was the system in accordance with which the statistical experience was compiled, and each departure from it involved the scrapping of data and the injection of personal judgment into the process of rate making.

[1] Most companies now write some substandard risks, and certain companies have also created a preferred class on which a better-than-average experience is expected.

[2] Other methods of handling substandard risks are sometimes used; for a discussion of these the student is referred to Maclean, "Life Insurance," Chap. X.

2. Every businessman is especially concerned in seeing that his costs, including the cost of insurance, do not exceed those of his competitors producing the same line of goods. If he can get a special rate on his risk as unique and in a class by itself, which he thinks is lower than that of his competitors, he will seek it. If he cannot, he wants the class rate based on product, which will presumably assure him the same rate as his competitors.

3. Analysis clearly shows that the risk of industrial injury is dependent upon the process or operation performed and that the same product may be produced by quite different processes.

4. Since the premium is found by applying a rate to a pay roll, if the classification system is such that individual risks are covered by more than one classification, there is afforded an opportunity so to keep and report the pay-roll records in an individual risk as to load an undue proportion on the lower rated class and deprive the company of a considerable part of its proper premium income. Despite the audit privilege of the company, it cannot wholly prevent this.

5. In modern industry most factories produce many kinds of products and use a variety of processes.

In the discussion of this problem, two schools of thought have developed. One, feeling that process is the key to the degree of hazard, have advocated classifications based on process. The other, feeling that unfair division of pay roll is a greater evil than lack of precision in rate detail, have advocated a product basis, with the most important product of a plant determining its class. The resulting manual has been a compromise, but at the present time product is the primary basis, and the manual contains elaborate rules for the treatment of pay roll where more than one class of product is turned out or where multiple operations are carried on.

The following citation of cases illustrating the two points of view and the problems involved may make this point clearer:

In the past, proprietors of laundries have pointed out that sorters and markers are not exposed to the operative hazards and have suggested that their pay roll should be separately classified and rated. But in a given type of laundry the proportion of sorter-and-marker pay roll to the total is fairly uniform, and the resulting average rate would be the same as it is when one rate is

made for the entire pay roll. The only effect of the separation would be to tempt some proprietors to misclassification. The trade has come to realize this, and the single-class rate for a finished-work laundry has long prevailed without objection. On the other hand, in building construction the proportions of carpentry, plumbing, and painting work vary from job to job. Union rules prevent the interchange of labor, and there is no problem of misclassification involved when separate rates are applied to the several pay rolls involved. In the early manuals there were separate classes for inside and outside painting. The same painters may do either or both on the same job, and there is seldom any need for keeping separate pay-roll records except to determine the insurance premium. Reports of experience clearly showed a tendency of the insured to report as much as possible of his pay roll under the lower rated inside-painting class. Despite the apparent difference in hazard, the only solution that could be found was to make one class and rate for painting. The inequities, if any, that result from this are, in part at least, corrected through experience rating.

Accident Insurance.—In the field of personal-accident insurance, where occupation is the basis of classification, 10 arbitrary hazard classifications have long been in use as follows:

Number[1]	Classification name	Code[1]
1	Select	A
2	Preferred	B
2+	Extra preferred	C
3	Ordinary	XC
4	Medium	D
5	Special	XD
6	Hazardous	E
7	Extra hazardous	F
8	Perilous	FF
9	Extra perilous	FF

[1] Used by some carriers instead of the class name.

The carriers' manuals then classify all occupations as falling into one of these, and the rates and policy terms are fixed accordingly. Most commercial carriers confine their writings to the first four classes.

It is beyond the scope of this book to enumerate all classification systems in use in the making of insurance rates, or to discuss their theory. The above discussion should indicate to the reader the purpose and place of classification in insurance rate making, the nature of the problem involved, and the methods that have been developed to meet it.

Problem of Competition.—When the retail clothier advertises a suit of clothes for sale, he knows the cost of the suit to himself and knows, or should know, how much the proceeds should contribute to his overhead. He may, therefore, fix his selling price with considerable confidence and make proper allowance for competition and other factors. But the underwriter taking an insurance risk is dealing wholly in the future. He may know accurately his expense, but the risk cost must be estimated. Insofar as the experience of the past is repeated in the future and he has a record, written or in memory, of the experience of the past, he is on as safe ground as is the retailer. But to the extent that either the future does not repeat the past or he lacks a correct record of past experience, he is guessing.[1]

Since "hope springs eternal in the human breast," there is always a tendency for some underwriters to think or hope they may be able to secure just a bit better result from a risk, or group of risks, than their fellows. The same eternal hope also leads many, even good businessmen, to believe or hope that a particular insurance carrier which underbids the others has made the only correct estimate of their particular risks and, despite rumors that its financial condition is none too sound, will prove in the end worthy of confidence. At least that hope is strong enough to induce them to "take a chance" for the sake of the price differential.

Under such conditions, unregulated competition leads to rate wars which vitiate the financial foundation of the business, or to commission wars which are even more detrimental to the interest of policyholders and public. Whatever may be said for competition as a regulator in other economic fields, it works badly

[1] It is not meant to be implied that risk is not present in retail merchandising, but the risks are of quite different nature from those encountered in insurance.

in the making of insurance rates.[1] As a consequence of this condition, rates are generally made in conference rather than by individual insurance carriers. In some fields, as, for example, in life insurance, each individual carrier makes its own rates, but here a statutory basis for setting up liabilities serves to keep rate competition within reasonable bounds. Where competition has run up expenses to an undue degree, the state has had to step in and regulate them.

Competition between types of carriers is usually on a rate or net-cost basis, *i.e.*, a comparison of the nonparticipating rate with the rate after deducting the dividend of the participating carrier. The element of competition is never ignored, nor can it be, in insurance rate making, but it cannot safely be the controlling regulator. Where the state has not stepped in to control it, the companies have usually voluntarily associated themselves for the purpose, often in defiance of mistaken statutory efforts to foster competition.

Rates and Prevention.—From the standpoint of the ultimate good of the community, the prevention of loss is much more important than its distribution through insurance. Therefore, that system of rate making is best, other things being equal, which most encourages loss prevention. This is another reason why rates should be equitable, for if one, having a risk that he knows is poorer than that of his neighbor, is called upon to pay no higher premium, his interest in reducing his hazard is in no way stimulated, and the morale of the whole community who may know of the fact is broken so far as interest in prevention is concerned. If, however, the rates charged for various risks conform quite closely to their inherent hazard, incentive to prevention is held before all, provided the difference in inherent hazard is recognized by the community or adequately presented to it.

But individual risks presented to an insurance carrier for coverage are usually composites of several partial risks which vary greatly in individual cases. There are various ways in

[1] Some states have tried to force competition in insurance rate making and to forbid conference or cooperation. This has proved ineffective or injurious wherever tried and is now generally abandoned. Compulsory cooperation with official regulation has in many cases replaced the theory of competition as a regulator.

which the composite risk may be broken down into its component parts. For example, one way in the case of fire insurance would be according to provoking cause, such as spontaneous combustion, communicated fire, etc. From another point of view, the sequential relation might be the basis of the analysis. A fire loss begins in ignition, is continued by combustion, and delimited by the damageability of the property insured. In any practical attempt at loss prevention, in an individual risk, the total risk must be analyzed into its elements and each one studied to see where improvements can be made.

This work will be stimulated if the insurance rate for an individual risk is built up synthetically by considering the several elements making up its hazard, and by making a proper charge for each. The attention of those attempting its improvement is thereby directed to the weak points. Usually also, it involves greater cost to construct a building or a piece of machinery with a view to safety, than is required when no attention is paid to the element of risk. If it is apparent that less careful construction or designing will impose a continuously recurring penalty in the form of higher insurance rates, those responsible for determining design may consider the capitalized value of this charge as an offset loss to the saving by cheaper construction. Better construction will usually result from consideration of these factors. If the capitalized value of the extra premium is less than the cost of better construction, the improvement will not be made. In this case, the analyzed rate would discourage improvement. But, if the extra rate properly measures the loss-producing cost of the deficiency, then the superior construction, if undertaken solely for loss prevention, would be wasteful. If, therefore, the analysis of the risk has been sound, the measurement precise, and the present value of excess charges properly estimated, the analytic method of preparing and quoting rates will not only make for preventive effort in the aggregate but will also tend to direct expenditure into the most profitable channel. Although what has been said has been with reference to new construction, the same line of reasoning applies to subsequent improvement, and with even greater force to current expenditure for protection.

The installation of an automatic sprinkler system requires a considerable capital outlay. The owner of a building in deciding

whether he should install one usually considers the reduction of his fire-insurance rate which would follow. If that reduction, less the cost of the sprinkler-leakage insurance which he will then also need to carry, would be a good return of the capital invested, he will probably put it in; otherwise he will not. The minimizing of loss due to a sprinkler system in a large store or warehouse would probably make it a socially desirable expenditure, and the reduction in rate which it would bring about would probably lead to its installation. But a sprinkler system in a private dwelling would hardly save enough fire loss to justify the expense, and the rate reduction that might be allowed would not encourage the wasteful use of the material involved.

In response to this line of reasoning the making of fire-insurance rates for many types of risk is by means of schedules, in which the separate parts of the risk are individually considered and the rate for the total risk arrived at by a process of synthesis. In workmen's compensation insurance also, the class rate is sometimes modified by the application of a schedule to a report of inspection of the plant, setting forth the types and condition of hazardous machinery found therein. In most other branches of insurance it has not yet been possible to develop analytic rating.

In what has been said about the effect of this kind of rate making on preventive effort, it has been presumed that it is possible to arrive at a correct estimate of the several partial hazards, or at least at a reasonably close approximation. Whether this is possible is still a moot question. Present fire-insurance schedules do not rest on statistical data for their values, and those used in workmen's compensation insurance,[1] only partly so. This topic will be further considered under the next heading.

In certain fields, it is recognized that the morale of the risk is almost as important an element as the physical hazard. This is difficult, if not impossible, to get at by inspection. Yet, if the theory of encouraging reduction of risk through analytic rate making is sound, inducement to good morale by lower rates on risks where it is above the average, and by higher rates where it is below, would appear desirable. The effect of the morale is found in the loss record, but for most lines of insurance the expected loss frequency per individual risk is so low that it is

[1] Schedule rating in this field persists in only a few states.

not feasible to give attention to the experience of the individual risk. In the case of workmen's compensation insurance, however, it has been deemed possible to give some weight to the individual risk experience in determining its rate, and a system of experience rating is applied to modify the class rate, which has already in some cases been modified by the schedule.[1]

Statistics and Rate Making.—Statistical data are used in rate making for either of two purposes:

1. To true up an existing scale of rates either by changing its average level or by changing the relation between the rates for the several classes, or

2. To make a new scale of rates for either a new carrier or a new line of insurance or to replace an existing scale, when that seems better than modifying an existing one.

In any event, in the long run, the premium income of an insurance carrier must be sufficient to meet its losses and expenses. A given set of rates may be inequitable by reasons of unfair charges for expenses as well as of unfair charges for losses. The allocation of joint costs is always a difficult problem in cost accounting and price making. Until comparatively recently the solution in insurance, except in life insurance and to a certain extent even in that field, has been by rule of thumb. Now the problem is receiving much attention especially by life-insurance carriers and multiple-line casualty carriers.

Expense Analysis.—The expenses of an insurance carrier may be classified in two groups:

1. Those incurred and paid in connection with individual policies, principally agents' commissions and taxes.[2]

2. Others. These include many types which, though not paid or accounted for in connection with individual policies are so incurred, such as printing policy forms, recording of policies, auditing of exposures, and settlement of losses, etc. There are also expenses which are not so incurred: rent, general advertising, salaries of executives, etc. These require allocation as between

[1] Lately attempts have been made to do so also in the case of automobile-liability insurance, particularly where fleets under common control are under consideration.

[2] Taxes are not *paid* in connection with individual policies, but since they are in the main percentages of premium they may be so regarded.

lines of insurance in a multiple-line carrier and within the line in such a way that the charge for them in the rate is equitable.

Taking all the expenses into account, for purposes of allocation they may be classified as follows:

1. Those proportional to gross premiums,[1] mainly those in the first of the above two classes. Some of the joint expenses may be properly allocated in this proportion.

2. Those in proportion to losses. The major item here is loss-adjustment expenses

a. Directly assignable to individual losses.
b. General—the overhead of claim departments.

In addition to these it is fair also to assign some part of the general overhead as loss expense.

3. Those proportional to units of exposure. The major part, but not all, of the expenses of underwriting, pay-roll auditing, and engineering and prevention work fall in this class. It takes more time and expense to inspect or audit a large plant than a small one, but the increase is not in strict proportion to size.

4. Those proportional to the number of policies or items handled. In this class fall the printing of forms, recording, etc. But again more expense may be incurred for policies of large size and extensive coverage than for small ones.

It may be just to apportion some kinds of expense as falling partly in each of these classes, and the proper proportions may vary according to the manner in which a given carrier conducts its operations. Unfortunately the segregation of expenses required in the annual statements for the insurance commissioners do not key in very well with this type of analysis. The extent to which individual carriers so analyze their expenses varies greatly. Life-insurance companies are the most careful in their expense analyses, the nonparticipating companies for rate making,[2] and the companies issuing participating policies for the purpose of determining dividends.[3]

[1] The premium paid by the policyholder.

[2] See Cammack, Edmund E., "Premiums for Non-participating Life Insurance," *Transactions, Actuarial Society of America*, Vol. XX, pp. 379*ff.*

[3] See Maclean, Joseph B., "Life Insurance," Chaps. V, VIII.

Many states have statutes that forbid carriers to discriminate in rates between risks of the same degree of hazard, which have in some cases in the past been held to prohibit variation in rates by size of risk.[1] This attitude precludes provision in rates for any expenses on a per-policy basis, though there is an old practice in the field of accident insurance of charging a policy fee in addition to the premium. It would be logical to derive the gross rate by loading the *pure premiums* (loss cost per unit of exposure) for expenses by adding a percentage and a fixed amount in dollars. The practice until very recently, except in life insurance, has been to load a uniform percentage. Recently, rates for workmen's compensation insurance have provided an expense margin of a percentage of the gross rate decreasing with the amount of the total premium to be paid by the individual policyholder, *i.e.*, mainly by the size of the risk, though higher rates for more hazardous operations have the effect of an increase of the total premium.

Truing Up a Rate Scale.—If expenses are provided for as a fixed percentage of the gross rate, the premium dollar may be divided into two parts: one for losses and the other for expenses.[2] This division is usually expressed in two ratios; the loss ratio and the expense ratio. The expense ratio is usually fairly constant, over short periods at least, for carriers of a given type as a whole and for well-established carriers within each type. Over the long range it has changed slowly, increasing at a fairly steady rate up to about 1920 and then tending to level off. Loss ratios on a given scale of rates fluctuate more in response to general conditions. It is thus possible, having regard to proper contingency margins, to set a desired *standard loss ratio*. If, for example, it appears that 50 cents out of each premium dollar will be needed for expenses, contingencies and profit, the standard loss ratio will be 50 per cent.[3] If 40 cents will suffice for these purposes, the standard loss ratio will be 60 per cent.[4]

[1] Recently, graduation of rates by size of risk has been permitted in workmen's compensation insurance.

[2] There may be a margin for contingencies or profit, but this, like the expense margin, is usually set as a percentage of the gross rate.

[3] This is about the normal for fire insurance and some other lines.

[4] This is about the standard for workmen's compensation insurance.

Under the conditions just assumed out of $100,000,000 of premiums in fire insurance, for example, about $50,000,000 would be required for expenses of a company paying the customary agency commissions. Owing largely to the lower commission scale prevailing in workmen's compensation insurance, only about $40,000,000 would be so required. Assuming that investment earnings yielded an adequate return for the stockholders,[1] there would remain for the payment of losses in the first case $50,000,000 and in the second $60,000,000. Now, let it be supposed that the loss experience under $100,000,000 of fire-insurance premiums is examined, and it is found that the losses have been $40,000,000. There has been a profit of $10,000,000 above that contemplated. Rates have been apparently too high. Assuming that there was no reason to suppose that the same volume of risks would produce a different result in the future, the rates should be reduced. If expenses remain at a fixed percentage of premiums, a reduction of 20 per cent would restore the anticipated balance. The premiums, on the same volume of risks would be $80,000,000, the expenses at 50 per cent would be $40,000,000, and the $40,000,000 remaining would just meet the expected losses. The loss ratio would be 50 per cent whereas under the old (too high) scale it was only 40 per cent.

Following the same reasoning, if the losses had been $60,000,000 and the expenses $50,000,000, the carriers would have sustained a loss of $10,000,000 and, if there were not some conflagration or unusual condition to explain the higher losses, *i.e.*, if the same volume of risks might be expected in the future again to result in $60,000,000 of losses, the rates should be increased 20 per cent. This would give for the next period on the same risks $120,000,000 of premiums with expenses at 50 per cent, requiring for their payment $60,000,000 and leaving $60,000,000 to pay the losses.

These adjustments, it should be noted, would not be for the purpose of refunding past profits or recouping past losses. They are "water over the dam."[2] The purpose of the adjustment would be a more reasonable or safer rate scale for the future.

[1] See pp. 426–430.

[2] If the insurance were all in mutual companies, an adjustment might be made by dividends or assessments (if present surplus could not absorb the loss) as well as adjustment of rates for the future.

How the adjustment would be made would depend on how the earlier rates were made and upon analysis of the actual losses. The technical problem is too complex for discussion in an elementary text.

The comparison of an actual loss ratio with a hypothetical standard as a test of reasonableness and adequacy of a rate scale appeals to common sense and has been attempted by persons not closely familiar with the business. Unfortunately they have often been misled by using an improper ratio. The ratio to be used is that of *losses incurred* on the business tested to *premiums earned.* These figures are obtainable but are not those most readily available, which are *losses paid* and *premiums written.* If the volume of business is fairly stable, the ratios on the two bases will not be far apart; if the volume is increasing,[1] the latter ratio will be too low and indicate an unwarranted reduction; if the volume is shrinking, the reverse will be the case. If the business is increasing in volume, the amount of unearned premiums at the end of a test period will be larger than at the beginning. The total of premiums written will be larger than that of premiums earned by the excess of the unearned at the end of the period over that at the beginning. Likewise there will probably be a larger volume of losses unpaid (in process of adjustment) at the end than at the beginning. Thus the total losses paid will be less than the losses incurred. The ratio is, of course, reduced both by the numerator of the ratio fraction being too small and by the denominator being too large. In a period of shrinking volume of business these conditions are reversed. The proper data for passing from written to earned premiums and from paid to incurred losses can be obtained by noting the liabilities for unearned premiums[2] and unpaid losses,[3] as set forth in the balance sheets of the carriers, at the beginning and end of the period whose experience is studied.

Coinsurance Allowances.—Frequently it appears that relativities are fairly stable. Then a general level or average rate may be set, and the scale of relativities may be applied to it to determine individual rates. Instead of specifically determining the

[1] This is generally the case.

[2] See pp. 442, 451.

[3] See pp. 438, 440, and 445–451.

rate for different percentage coinsurance conditions a general scale of allowances is usually expressed as a percentage of the rate for insurance without coinsurance allowance. The rate for the individual policy with a given coinsurance provision is then the corresponding percentage of the rate that would be charged the same risk for a policy without the provision. If a scale of relative frequency of loss by percentage of value such as shown on page 91 is fairly constant, the no-coinsurance rate could be set by comparing the total losses incurred to the amount of insurance corresponding to the average practice of the insured. Using the figures given on page 91, the total of values involved was $1,000,000. If, on the average, the ratio of insurance carried was 50 per cent, the total insurance would be $500,000. Ignoring the expenses, an average rate of $0.15 per $100 would be required to pay the $738 of losses.[1] Twelve cents[2] is 80 per cent of this. Thus for a 70-per-cent clause; the rate would be 80 per cent of the without-coinsurance rate; for an 80-per-cent clause, it would be $^{11}/_{15}$ or 73.3 per cent of the without-coinsurance rate. The figures used are arbitrary and illustrative only. The allowances are usually rounded out. Data as to their determination in any jurisdiction have not been published. They probably rest largely on expert judgment. This discussion attempts only to show the principle involved in such determinations.

Setting a New Scale of Rates.—If the rate scale used over the test period was not stable, a new type of statistical data is required, since to fix a new scale of rates it is necessary to determine a *pure premium* for each class and to add the appropriate loading for expenses.

The pure premium has been defined above—the net incurred-loss cost per unit of exposure to loss, for example, in workmen's compensation insurance, per $100 of pay roll. Pure premiums must be found for each class for which a rate is to be made. For this job special statistical records must be kept, for the premiums and losses are analyzed in the general accounting records to kind of business only and not to the several classes within each field. The exposures do not appear in the general accounts at all. As a test of general accuracy, these records must, however, check with

[1] On losses exceeding 50 per cent, only the face of the policy would have been paid. The unpaid part of the losses in excess of 50 per cent totalled $178.

[2] The net premium shown on p. 91 for a 70 per cent ratio of insurance to value.

the general accounts. Statistical records are generally made up by the use of punched cards and mechanical sorting and tabulating machines. Classes are indicated on the cards by a numerical code as are other facts, *e.g.*, district or agency, according to which it may be desired to sort and tabulate the data for other purposes. It is fundamentally important that the class coding both of premiums and of losses be accurate. Any inaccuracies produce corresponding inaccuracies in rates. When, as is usually the case, rates are made from the combined experience of several carriers, the work in each office must be correct. Errors in the data contributed by any one carrier affect, to the extent of that carrier's data in proportion to the whole, the accuracy of the combined data. An adequate presentation of the methods of preparing the statistical data for this work would require so much description of technical office procedure that it seems inappropriate in a general text. The references at the end of this chapter will serve the student who desires to follow up this phase of the subject.

Schedule Rating.—The complexity of fire-rating schedules and the difficulty of accurately determining the causes of fire losses[1] have, so far, made it impossible to compile statistical data on the item values of existing schedules or so to test their accuracy and adjust them. The late E. G. Richards devised the Experience Grading and Rating Schedule which might have yielded an approximation to that result, but it has not anywhere been put into effect. Mr. Richards proposed that committees of engineers develop grading standards within each class which would permit the assignment of each risk to one of 10 grade classes and that the record of losses and exposures be kept, within each class, by grades. In that way the proper relation between grades would be established on a statistical basis. The grading standards would, however, still rest on engineering and underwriting judgment, checked in part by laboratory experiment.

Problem of Changing Conditions.—The foregoing discussion of the place of statistics in rate making has been based on the assumption that the future accurately reflects the past. But this assumption is not in general true. The changing condi-

[1] Frequently the loss is the product of a combination of causes, no one of which alone could have produced it.

tions of life reflect themselves in correspondingly changing risks. Since the insurance contract covers the future, the rates must be fixed for the future. Can this be done on a statistical basis?

Much discussion has centered around this question, and opinions among experienced insurance technicians differ widely on it. In certain fields, *e.g.*, life insurance, hazards change so slowly that statistical bases in the form of mortality tables derived from the not very distant past may be, and are, used with confidence. But in other fields, changes in the value of the risks assumed are more frequent and more violent. The investigations that have been made into the nature of these changes and the possibility of forecasting them in the several risk fields are highly technical. An adequate discussion of the problem is beyond the scope of an elementary treatise. It is mentioned here because of the important question thus raised as to the practical validity of an unadjusted statistical basis for insurance rates. Where statistical data of a past period are taken as a starting point, such adjustment, on the basis of either scientific investigation of underwriting judgment, as will give reasonable recognition of the changes up to the time rates are made and with proper regard to the prospects for the time to which the rates will apply, is essential.

RATE-MAKING PRACTICES

In the foregoing discussion an attempt has been made to analyze the problem of the rate maker. Attention may now profitably be given to the practices in meeting this problem as it arises in some more important branches of the insurance business.

Life Insurance.—Owing to the practice in life insurance of quoting rates only on standard lives and considering age alone as the basis of classification, the problem of measuring the hazard for each class is reduced to the selection of a suitable mortality table showing the rate of mortality by ages. However, as noted in Chap. X, the life-insurance policy covers a long term of years, and payments of premium or benefits due in the future are worth in present value less than their face. The actual present value depends upon the rate of interest at which money can be invested. Hence, in addition to the mortality table which most closely reflects the mortality, the insurer must fix upon a rate of interest

which it is likely to realize on its investments over a long term into the future. With these factors as the basis, it is possible to find, by well-established mathematical methods,[1] net premiums for each plan of insurance at each age.

There are a number of mortality tables, among which the one most closely following the class of risks for which the rates are to be made should be chosen. The skillful actuary will also examine the past experience of his own company or, if it is a new one, the experience of other companies whose general methods are to be followed, to find the most suitable basis.

The actuary is not entirely free in his choice of table and rate of interest. As will be explained more fully in later chapters, the life-insurance company must accumulate certain reserves to maintain its solvency, and the statutes prescribe the mortality table and maximum rate of interest that must be used to determine those reserves.

Having found the net premium[2] at each age for each type of policy, the actuary must next consider the expense requirement. Expenses are much larger for the first year of the policy than for any subsequent year, but they must be suitably spread over the period for which premiums are to be paid, since it is essential that the premiums remain level for the term for which they are payable. In doing this the company must consider the equities between different classes of policies in order that no class be made to bear an undue share of the expenses of the company. In general it would unfairly distribute the expense burden to provide for it either by way of a fixed percentage increase on the net premium, or by a flat addition to the net premium. The more usual plan of finding the gross rate is by adding to the net premium a percentage of itself and a flat sum in dollars.

Having found a tentative set of rates in this way, it is necessary to examine the rates of competing companies, not only in the aggregate but by plans and ages at the time of issue of the policy,

[1] It is hardly within the scope of an elementary text on insurance to develop and explain these special methods. They are presented with some detail in most texts on life insurance and are explained fully by E. P. Spurgeon, "The Text Book of the Institute of Actuaries," "Life Contingencies."

[2] That part of the premium which provides for losses, with allowance for interest to be earned.

for otherwise the company might find that the business it most desired was going to its competitors, and that its relative scale of rates brought to it too much of the business of those of more advanced age or too much of the short-term business. The aim is a fairly balanced volume according to age distribution and plans offered. Finally, the rates must be reviewed to see that the gross rate does not fall below the net premium corresponding to the statutory reserve basis.

The process of rate making must be much more exact in the case of nonparticipating than participating insurance, since, in the latter case, inequities can be further adjusted in the process of distributing the surplus.

The effect of statutory bases of reserves which automatically set minimum limits to the rates that may be quoted has precluded the necessity of cooperation between the companies in rate making. But through the various actuarial bodies the companies have been led into a high degree of cooperation in the investigation of their mortality experience in various ways useful for rate making, for classifying substandard risks, and for other purposes.

Marine Insurance.—There is no advance publication of rates of marine insurance. A broker, representing the owner or prospective insured, approaches an underwriter and submits the proposal to him, usually suggesting a rate. As nearly as can be gathered from statements of underwriters in public hearings and elsewhere, the underwriter has available for immediate review a record of his premiums and losses on risks submitted by that broker. He also has records of his experience in that trade, *e.g.*, coffee shipments from Rio de Janeiro to New York, and he looks up the rating of the vessel in Lloyd's Register, or in that of one of the other classification societies. He considers the season of the year and its probable affect on the venture, and either accepts the risk or names another rate at which he will accept. Both broker and underwriter keep in touch with local and world-wide insurance markets, and the final rate is a matter of bargaining between them.

Fire Insurance.—In fire insurance the practice has grown up of delegating rate making to central offices and bureaus for particular regions of the country, each of which makes rates for all

companies affiliated with that office. This is natural since combination of companies is necessary to prevent rate competition and the inequitable and unsound rates resulting therefrom, and since the conditions of construction, fire protection, wind, and climate, all of which affect the hazard, differ materially in different parts of the country. Not all companies do business in all parts of the country, and the laws of the several states differ materially, so that it has not been found feasible to maintain one central office.

Rating offices are usually under the control of a committee of branch managers or general agents of the companies with wide discretionary power. Sometimes, as in states where anticompact laws still exist and forbid the companies to cooperate in rate making or agree on rates or practices, an individual expert sets up a rating office and promulgates advisory rates which are generally used. Always, unless prevented by statute, there are companies which do not adhere to the board or bureau, and whose rates appear to be based on those of the board, with such competitive discount as appears desirable to get the business that they expect will be profitable.

Two classes of rates are found in fire insurance: These are *class* or *minimum* or *tariff rates* (the several terms are used in different parts of the country) and *schedule* or *specific rates*. Class rates apply to whole classes without differentiation of individual risks according to their own condition except that penalties are imposed for unusually hazardous conditions, *e.g.*, a metal flue passing through a floor or wall and not properly protected, or credits given for such items as noncombustible roofs. The classes for which such rates are used are those where the units are small and the hazard low, so that the premium on any individual risk is so small that the cost of inspection would be very large in proportion to it. The outstanding classes of such risks are the detached frame dwelling house and the detached brick dwelling house. These classes are usually "preferred" classes and, in some jurisdictions, term insurance for 3 years is granted at twice the rate for 1 year, and for 5 years at three times the rate for 1 year. The justification for so large a discount in the term rate is hard to find unless it be in an excessive annual rate. There are some obvious advantages to the company in the term risks. The

basis of preference for these risks is not wholly in excessive rates, since by reason of the small size of the individual risk and the large number of such risks, they constitute a class likely to produce a very regular experience, with few serious departures from the average experience.

Each rating organization has some schedule or schedules by which it arrives at specific rates for risks not subject to tariff rating. There are several such schedules, and no adequate understanding of the individual schedules and their differences can be conveyed within a few pages. An attempt will be made only to present the general theory of this method of rating.

All such schedules start from a base rate which does not rest on a statistical comparsion of *risks assumed* and *losses incurred;* it is arrived at as a matter of the combined personal judgment of the committee in charge and checked by studies of the ratio of aggregate losses to aggregate premiums in comparison with a rough norm, or standard.[1] Committees meeting at intervals adjust it up or down so that its use in connection with the schedule will probably restore the loss ratio to the desired normal.[2] The base is then modified by a factor to get the city key rate which is the rate for the standard building contemplated by the schedule in that city. The nature of this standard differs in the several schedules. It may be a high standard, in which case the individual rate will be found from it largely by the addition of charges, or it may be a low standard in which the individual rate shows more credits than charges.

The factor by which the key rate is derived from the base is found from the result of a survey of the city by the engineers of the National Board of Fire Underwriters. That Board, which is not a rate-making body, has developed a grading scheme for measuring relatively the standing of cities with regard to fire prevention and protection. It is based on an analysis of conditions of a city relative to the fire hazard, under which an arbitrary

[1] See p. 368. In fire insurance expenses and proper provision for conflagration losses require about 50 per cent of the premiums.

[2] Varying influences of schedule rating and actions of individuals in increasing or reducing their insurance, or transferring it from stock to mutual carriers, are such that a uniform percentage increase or decrease in a base rate may not give exactly the same percentage change in the rate level.

5,000 points of possible deficiency are apportioned to the different aspects, such as water supply, fire-department equipment and personnel, and street layout, and again subdivided within each division. A proper number of points is charged for each deficiency, and the rating of the city depends on the total number of deficiency points. The weighting of the several items is a matter of judgment of fire-prevention engineers but, if this is correct or approximately correct, the plan provides a measure for uniform application to the cities of the country by which their relative rank may be accurately gauged.

The schedules used for rating individual risks set up a standard building with which the individual risk is compared; charges for deficiencies and credits for superior features are listed, as well as rules for taking account of the influence of surrounding risks known as *exposures*. In some of these schedules, notably the *Universal Mercantile Schedule*, the charges are in flat amounts and are added to the key rate regardless of each other or of the occupancy of the building. The standard for this schedule is a high type of building, and credits are not provided except for removal of conditions, which are under control of the insured, or for conditions of unusual advantage. These credits are percentages of the finally built-up rate. In other cases the charges and credits are uniform percentages of the key rate and are added to, or subtracted from, it. In the construction of the widely used *Dean* or *Analytic Schedule* the effort was made to express relationships. Its form is consequently more complex than that of earlier schedules. Careful analysis of the physical phenomenon of fire loss underlies the structure of this schedule, but the item values are matters of expert judgment of rating engineers and are not based on statistical data. There are different schedules for the different types of construction such as Class A, Class B, Ordinary, etc., and an important element of each schedule is the classification of the occupancy.

Separate schedules are also used for *sprinklered risks*[1] which generally contain fewer items because it is found that the protection of the sprinkler is so great that the other points are minor. *Special hazards*, as certain types of manufacturing operations

[1] That is, those protected against fire loss by automatic sprinklers.

are termed, are also rated by schedules designed to fit the peculiar operations covered.

Whether fire-insurance rate making can ever be placed on an absolute statistical basis is a question about which widely varying views are held by students of the problem. There will probably always be found those who hope for the day when fire-insurance rates will be determined by methods recognized as equally well founded and scientific as are those by which life-insurance premiums are calculated. There will probably also always be the analyst who sees in the multifarious possible causes of fire damage to any individual risk, including damage by communicated fire, such complexity as to preclude any possibility of statistical control. In the supervision of rates and rate making, the companies are faced with constant necessity of justifying their position, usually by statistical evidence. This holds the potentiality of forcing such attention on this aspect of the problem as may lead to a reasonable and suitable statistical control on the major features of the rate-making procedure. The example of the evolution of rate making for workmen's compensation insurance may lead the way in this direction, though that evolution has not yet advanced to the point of entire satisfaction to all concerned.

Workmen's Compensation.—From the beginning the rates for workmen's compensation insurance have been subject to state regulation in the important industrial states of Massachusetts and New York, and, therefore, methods of rate making have had to be devised under which the rates produced could be justified to the insurance officials of those states. Many other states have since assumed supervision of rates, and it has not been possible for the companies to do other than base rates on statistical evidence and give full publicity to their rate-making procedure. The rate for an individual risk is found by applying to the manual or base rate for its class a modification arrived at by use of an experience-rating plan applied to the insurance carrier's experience with the risk. The plans and procedure for developing both elements, manual rate and experience-rating plan, have undergone many changes, and it probably cannot be said that the present methods are the last word.

Rate-making Bodies.—In the industrially most important states there are state rating bureaus operating under close supervision of the insurance commissioners. The National Council on Compensation Insurance, a compact organization including nearly all compensation-insurance carriers, makes the rates, prepares the merit-rating plans for many states, and compiles data for some of the state bureaus. The Council had developed gradually from a loose federation of state rating organizations.

Manual Rates.—In all states class rates are set forth in a manual which also contains sundry rules for classification and rating procedure. In the states where a state authority[1] has jurisdiction over rates for workmen's compensation insurance, the manual and its classifications, rates, and rules must have official approval. That approval is usually conditioned upon supervision of their use by the rating bureau designated by the state for that purpose. The manual rates are usually prepared by a committee of underwriters representing the carrier members of the bureau. The basis is a set of pure premiums[2] for each classification calculated from the most recent combined experience of all the carriers. These are compared with the pure premiums underlying the existing rates, and new pure premiums are developed to represent the committee's estimate of reasonable, adequate, and not unfairly discriminatory pure premiums for the period to which they are to be applied. The gross rates are then found by adding the appropriate loadings for expenses and contingencies. The technical problems involved in this work are such that adequate description is beyond the scope of an elementary text. Since the final result must be approved, usually after public hearing before the approving state authority, which is also usually advised by its own experts who have access to the data used by the committee and frequently sit in on its deliberations, there is a minimum of opportunity for improper action by the committee.

Experience-rating Plan.—In workmen's compensation, unlike many other branches of insurance, the loss does not come from a single event that may never happen. Usually in a risk of

[1] Usually the insurance commissioner but in some states the industrial commission.

[2] See p. 371.

large size a number of small losses and one or two large ones each year are normally expected. In a risk of better than average morale the losses will be less for the same physical condition than in one of mediocre or poor morale. If the risk is large enough so that accidental departures from normal probabilities are not very likely, its own experience may be the best index of its proper rate.

Most risks are not large enough to attach great weight to the indication of their own experience. But it has been found, both by mathematical investigation and practical experience, that it is justifiable and wise to give it some weight. Accordingly, the experience of the individual risk for a fixed fairly recent period, is worked up into a form in which its rate indication may be compared with the class rate. The final rate for the risk then lies between these two. If the risk is very large, the final rate will be nearer the indication of its own experience than the class rate, or class rate as modified by schedule if one is used. If the risk is small, the class rate dominates. The details of the plan are too complex to justify any attempt to present them in a general book discussing all branches of insurance.[1]

Automobile-liability Insurance.—Rates for automobile-liability insurance are generally not subject to approval of state officials, as are those for workmen's compensation insurance. But these lines are written largely by the same carriers that write workmen's compensation insurance, and their influence on rate-making requirements for that field has brought about a highly developed technique for making automobile rates. There is not, as for workmen's compensation insurance, a central rate-making body. But most of the stock companies writing these lines are members of the National Bureau of Casualty and Surety Underwriters, a reorganization of a bureau that formerly made rates for workmen's compensation insurance. This bureau makes rates for the automobile lines written by casualty companies, as

[1] There is now in use a plan for further modification of the individual-risk rate by a retrospective experience-rating plan where the premium exceeds $1,000. Under this an adjustment is to be made 18 months after the expiration of the policy in the light of its own experience. Some participating carriers base their dividends in part upon the individual-risk experience. Other modifications of individual risk rating are under consideration and have been adopted in some states.

well as for some other lines. Its methods have been given publicity and may fairly be said to determine the rates, though different rates are quoted by carriers not members of the bureau, whose competition cannot be ignored. The Mutual Casualty Insurance Rating Bureau is a similar organization.

The rapidly changing types of automobiles produced in the immediate prewar period, changes in policy provisions and in highway conditions, and the more recent war controls have presented constantly changing risk conditions in this field to which rate-making methods have had to be adapted. Probably an entirely new set of conditions will be presented in the postwar period. It therefore hardly seems desirable to attempt an outline of rate-making procedures. It is reasonable to expect that they will follow the general principles of statistical rate making developed for the workmen's compensation field with appropriate modification for differences in the nature of the risks covered.

Other Lines of Insurance.—In the immediately preceding pages an outline has been presented of the practices in rate making for the more important lines of insurance. Less publicity has been given to the processes in other lines. With the exception of personal-accident and health insurance, it may be said in general that rates are made by intercarrier bureaus upon statistical data submitted by the carriers. These data are combined and developed into rates by rate makers who are experts in each particular field. There is generally a greater reliance upon expert judgment than in the case of workmen's compensation insurance or of automobile-liability insurance, but more use of statistical data than in the making of fire-insurance rates. The objective of adequate, but equitable and reasonable, rates is the same.

In the case of commercial (1-year term cancelable) accident and health insurance, tradition has fixed certain relations between rates and principal sum, and the amount of weekly indemnity for the preferred classes. Competition, although keen, does not affect those relations but has tended to the introduction of new benefits and policy provisions, sometimes called "frills." Recently the companies have formed organizations for studying combined experience, but as yet actual rate making and policy forms are individual company matters.

SUMMARY

1. Premium rates must be adequate to produce the funds to pay losses and expenses.

2. They must be equitable between classes of policyholders.

3. By equitable rates is meant such relation that each individual insured is charged what would be his proportionate share, if all risks insured in his company were identical in kind and degree with his.

4. Inequitable rates are both unfair to the insured and, in the long run, dangerous to the carrier charging them.

5. The first step toward securing equity in rates is classification of risks:

   a. By nature of hazard, *i.e.*, field of insurance.
   b. By similarity of hazards, *i.e.*, loss-producing factors.

6. Supplementing classification by analytic rating permits larger and less uniform classes than when all risks in the class must take the same rate.

7. Systems of classification must be based upon characteristics that are easily recognizable and, if they are to be satisfactory to the public, upon characteristics that appear to differentiate nature and degree of risk.

8. Illustrations from several fields of insurance show that classification in practice has approximately conformed to these principles.

9. Competition is a factor that cannot be ignored in rate making.

10. Unregulated competition tends to produce inequitable and, therefore, unsound rates.

11. Voluntary efforts at regulating competition are necessary when it is not held in check by state regulation, and such efforts will be made in defiance of mistaken statutes intended to foster unrestricted competition.

12. Inequitable rates tend to check efforts at loss prevention by reduction of hazard.

13. If the system of rate making shows clearly the relation between the rate and the removable hazards, preventive effort will be fostered.

14. It is desirable to recognize in the rate the influence of morale where that can properly be done.

15. Much labor is involved in establishing rates on a statistical basis but where practicable it is desirable.

16. Where rates are to be found from a statistical basis, comparison must be made between *losses incurred* and *risks covered.*

17. Accurate classification of both items is essential.

18. Rates should take cognizance of the ratio of insurance to value, wherever a considerable proportion of the losses are partial.

19. A coinsurance clause is necessary to assure maintenance of the agreed ratio.

20. Changing conditions with the passage of time tend to make past statistical data inaccurate and to require adjustment of its indications before they can be made the basis of rates.

21. The insurance carriers in each field have adopted what seemed the most appropriate method to reach rate equity.

22. In some cases very elaborate methods have been developed and are applied at the cost of much labor and expense.

23. This is especially the case where the rates must be approved by state authorities before they can be used and where, therefore, the basis of derivation must be justified.

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CHAPTER XXI

UNDERWRITING

The individual risks assumed by insurance carriers are not, like certain types of machinery, each an exact duplicate of every other. Such exact duplication is not found even within any class of risks for the purpose of rate making. And probably no refinement of rate-making technique can find the rate that exactly measures each risk to be insured. Fortunately such precision of risk measurement is not necessary to a satisfactory functioning of the insurance business. But, unless insurance of a particular type of risk is compulsory upon all and is required to be in a monopolistic institution, the inability to make such precise measurement does impose upon the insurance carriers the necessity of taking active measures to see that the risks assumed in each class are not the worst, or generally below the average of the class.

It is also necessary, in the interest of equity between classes of insured, to assign each risk as accurately as may be to its proper class. In the long run this is also in the interest of the carrier, for persistent overcharging by assigning to a class carrying too high a rate, although possibly yielding some temporary profit, would, when it became known, so injure the carrier's standing as to cause greater loss.

Even if these requirements are met, serious injury to a risk carrier is still possible through too great concentration of value exposed to a single chance. For example, fire-insurance companies have sometimes found their losses in the conflagrations that have occurred in large cities too great to be met, and liquidation has been necessary.

From the old practice of the marine insurers at Lloyd's coffeehouse signing their names and the amounts assumed under the proposed contracts, the term "underwriter" has come to mean one who is skilled in the estimation of risk and the proper terms of its acceptance by an insurance carrier. The work of meeting the requirements just noted is entrusted by each company to

underwriters, who collectively constitute the *underwriting department* of the company.

Functions of the Underwriting Department.—The functions of the underwriting department are two:

1. To secure a *safe* distribution of risks.
2. To secure a *profitable* distribution of risks.

In an earlier chapter the insurance business was spoken of as analogous to manufacturing; producing certainty as the finished product from risk as the raw material. In any line of manufacturing the quality of the finished product depends in large part upon the quality of raw material. All manufacturing enterprises maintain inspection departments and sometimes expensive laboratories to test raw materials in order that only a satisfactory and uniform quality of raw materials may be accepted and used. If it is possible to use different grades, this department classifies the material and assigns it to its proper use. The underwriting department of an insurance company has a precisely analogous function.

Adverse Selection.—The optimism of human nature is such that the best risks are least likely to offer themselves for insurance. Therefore, the risks that any insurance company finds easiest to get and to hold are the poorer in their class. Further, individuals, in the conduct of their affairs, naturally seek the most favorable terms for transferring their risks, as to both classification, policy forms, and rates. This same tendency to think first of his own interests leads the insured persistently to choose, where option is open to him, that benefit which he regards as most valuable. This tendency is usually not to the advantage of the insurance carrier and is known as *adverse selection.* The underwriting department must seek to overcome the effect of adverse selection by a careful selection of the better risks.

Volume of Risk.—It was pointed out in Part I that the insurance business was founded on the law of large numbers.[1] If the necessary conditions for the successful conduct of the business are to be realized, the carrier must secure an adequate volume of business to produce dependable average results, and so far as possible it should obtain such a volume in each class. It is the

[1] See pp.12 *ff.*

function of the underwriting department to advise with the business-getting department to this end. In times of prosperity, when business is booming and losses few, some underwriters have overlooked the danger of adverse selection and have relied upon volume alone to give a dependable result. The subsequent loss ratios of their companies have usually had a corrective effect.

Spread of Risk.—Avoidance of excessive amounts at risk on a single hazard is, as has been noted, a further necessity to the safety of any insurance carrier. This involves the determination of the largest net amount the carrier will assume on a single risk, the *net line*, as well as the aggregate amount that will be taken in one group of risks subject to a single hazard, such as a conflagration in a congested community (fire insurance), a catastrophe in a factory or other risk covered by workmen's compensation insurance, or the loss of an excursion steamer whose passengers may have been covered by accident insurance in one company.

Favorable Selection.—Favorable selection involves not only the avoidance of excessive lines and adverse selection, but the deliberate selection of risks from those classes where the losses individually are apt to be small in comparison with the total value, the attempt to pick out of each class the best specimens, and the avoidance of classes where individual losses run close to the total insurance carried. For example, fire-insurance companies prefer private residences to sawmills, not solely because of higher relative rates (though there may be reason for believing the rates for residences are relatively high) but in large part because the losses on residences are usually small while those on sawmills are likely to be large. Again, some life-insurance companies writing only standard risks limit their writings as far as possible to certain forms of policies because the mortality of persons taking these forms is lower than among insured lives generally.

Methods of Underwriting.—Methods of underwriting differ materially from carrier to carrier and according to the kinds of business written. In all cases, however, the preliminary work of selection must be done by the agents in the field. Their work must rest upon the instructions from the head office. Instructions are communicated in part in rate books, manuals, and

circulars issued by the head office to all agents, in part by correspondence between the head office and the individual agent, and in part by oral instruction through special agents or in conventions of agents directly from head-office officials.

The agency instructions of a well-organized and managed company are of two forms:

1. Positive, setting forth the aims and desires of the office in regard to the business to be sought.
2. Negative, in the form of prohibited and questionable class lists and like instructions as to risks the company refuses or prefers not to accept.

Instructions of the negative type are communicated in definite terms, violation of which frequently carries a penalty. For example, life-insurance companies usually decline to pay for the medical examination of lives whose applications are submitted contrary to instructions.

Positive instructions usually cover two aspects:

1. Classes of business to be sought.
2. Amount to be written on any one risk.

Since all human rules are subject to exception, the procedure in cases where the agent feels an exception should be made should also be covered. This usually is covered by instruction to refer such cases to some supervising official of the carrier.

From this point, underwriting procedure differs markedly between those classes of insurance where the policy is written by the agent and those where the application is first submitted to the head office, which issues the policy. Before proceeding with the discussion of these methods, a brief description of the sources of information for underwriting will be given.

Sources of Risk Information.—As has been explained in connection with the discussion of the various policy forms, there is considerable variation in methods of obtaining information from the insured, relative to the risk he is offering.

In life insurance he signs a written application and also certain statements to the company's medical examiner. These become part of the contract and bind the insured as representations. In personal accident and some other kinds of insurance, signed applications are also often required. In the case of kinds of

insurance where an application is not taken, whether written on a schedule of warranties or not, some information is communicated to the insurance company's representative by the insured. These representations furnish the first evidence for underwriting purposes. Obviously, they are not adequate for thorough protection of the company.

The companies consequently seek further information by examination and investigation on their own behalf. This practice is most highly developed in the life-insurance field. Usually the applicant must be examined by a physician on behalf of the company, who sends his report of examination directly to the company or to a branch office in order to protect him from pressure by agents whose commission depends on the acceptance of the risk. Recently, some companies have undertaken the issuance of policies without medical examination. In such cases the statement required from the applicant is more rigid, and more careful inspection is made.

In addition to arranging for the medical examination, the branch office of the company, on receipt of the application, refers the case either to its own *inspection department*, if one is maintained by the company, or to an organization whose business it is to investigate risks for life-insurance companies. These agencies attempt to ascertain the financial standing of the applicant, his associations and habits, and any facts about him that would tend to show whether he is a satisfactory risk. Such reports are, of course, sent directly to the company's head or branch office, and are held highly confidential.

Since the dishonest person who fails in his first attempt is persistent and will usually apply to some other company, concealing the facts he believed the cause of his prior rejection, it is desirable for the companies to be warned of rejections. Most of the life-insurance companies operating in the United States are members of the Medical Information Bureau to which rejections are reported, with particulars for identification and a code designation of the cause of rejection. Cards carrying this information are sent from the bureau to all companies and carefully filed. This indexed file is searched on receipt of any application at the home office as the first step in the underwriting procedure.

Some companies also request of an inspection company a

similar report on certain classes of applicants for automobile-liability insurance, *e.g.*, very young persons, such as college students, and those whose residence or other facts recorded in the declaration raise questions as to the possibility of the improper use of their cars, as in bootlegging or smuggling of immigrants.

Companies writing other classes of insurance have similar types of information on which to base underwriting action. Another example will probably suffice. Except in the case of isolated farm risks, a written application is not required for fire insurance. All company head offices, and most important branch offices or general agencies, are equipped with insurance maps prepared by a company that makes this a specialty. These maps show the location of all buildings in the area mapped, including outbuildings on the premises, such as garages, water towers, or storerooms. The type of construction and use are indicated by distinctive coloring and other markings. A glance at the map tells the experienced underwriter the physical nature of the risk offered. If he has doubts, he may usually obtain from the rating organization covering his territory[1] a copy of the inspection report on the basis of which its rate was fixed. He also has detailed reports of the National Board of Fire Underwriters relative to the characteristics of the community which are likely to affect fire risks in it. He can in that way judge the adequacy of water supply, fire department, and other protective features. Usually the underwriters have been special agents and are more or less familiar personally with the principal features of the cities and towns in the territory which they are underwriting. If the underwriter wishes additional information as to the financial standing of the owner, he may refer to the reports of such agencies as Dun and Bradstreet's or he may call for a special report. Here, as in other lines, the companies keep records of suspicious fires and claims corresponding to those of the life-insurance companies.

In some lines of insurance, such as workmen's compensation and to some extent liability insurance, the expected frequency of loss is such that the company may gain some evidence of the degree of risk from its own files. In companies writing such lines of insurance it is customary for the underwriting department

[1] See p. 376.

to review the record of each risk for a reasonable time before the expiration of the policy and, if it is not considered a desirable risk, to notify the agency of its unwillingness to renew. On many risks carried for long terms, there is a considerable volume of data on which to base the judgment.

The greatest problem in underwriting is to avoid actual or potential fraud—what has been previously described as the moral hazard. No sure rule that will be an effective defense against moral hazard has been devised, nor can be. It would be an unwise and unjustifiable attitude for an underwriter to assume moral hazard in every case. But fraud uses so many and such clever disguises that he cannot afford to close his eyes to any suspicious indicia in the papers. Experienced underwriters, who have had some work in the adjustment of claims, seem to develop a sixth sense by which they detect such cases.

Mode of Selection.—The manner in which underwriting selection is practiced differs also according to the kind of insurance, depending primarily on whether the policies are issued by the head office or by agents.

When policies are issued from the head office, unacceptable applications are rejected, and the agents are notified to refund any payments accepted. This is regularly the practice in the life-insurance business.

If the risk is not wholly unacceptable but may safely be taken on some other plan or basis than that applied for, a policy on such a plan or basis may be offered. Since such a policy is not in accordance with the insured's order, it is necessary to send with the policy an amendment to the application, to be signed and returned by the insured in order to complete a binding contract.

In the workmen's compensation and kindred fields, where the company's records form the principal basis of its underwriting, the notice to the agent of the desire not to renew will generally prevent the applications coming in or, if the policies are written by the agent, the issuance of the policy. Similar notice may be given to agents in connection with personal-accident- and health-insurance policies if the company receives notice through claims or otherwise of a serious impairment of the risk.

In the case of policies issued by local agents without knowledge

of the underwriters until receipt of the daily report, the only alternative is to accept the risk or cancel. If cancellation is necessary, the agent is usually notified to effect the cancellation and is allowed a reasonable time in which to do so in order to protect his personal business interests. Cancellation causes so much inconvenience and dissatisfaction to all concerned that it is avoided wherever possible, and the underwriting department endeavors through special agents and notices to agents to prevent the issue of the policy in the first instance.

Competition.—Competitive conditions play no small part in handicapping underwriters in their work of selection. Most persons needing insurance place their orders through brokers and agents chosen because of personal friendship or business connections. Brokers and, to a limited extent, agents who represent several companies doing the same kind of insurance (a frequent condition in the fire-insurance business) may place any risk with whatever company they please. A particular company may be offered a volume of business of the kind it most desires and at the same time a few risks that it does not want. If the company wishes to retain the good will and patronage of the broker or agent in question, it may have to take the unwelcome business. Company representatives trying to avoid the undersirable risks have been told by brokers in such cases they must take "all or none." The underwriter faced with such conditions must weigh the advantages of the desirable business against the disadvantages of what he wishes to reject, and also give consideration to the value to his company of other patronage by the broker. He should not overlook the effect of a weak attitude on the future conduct of brokers. In too many cases in recent years, this fact has been overlooked to the detriment of the carriers.

Underwriting in the Drafting of Policy Forms and Endorsements. Careful draftsmanship in the preparation of policy forms greatly assists the underwriting work, and underwriters give much time and thought to the drafting of forms and endorsements as well as to instructing agents in their proper use. Carelessly drafted forms and the absence of appropriate endorsements may result in exposing the company to one or more types of hazard not a necessary or appropriate part of its business. Among these are

1. Assumption of additional risks not contemplated or provided for in the rate.
2. Abnormal moral hazard.
3. Abnormal morale hazard.
4. Adverse selection.
5. Nuisance claims, *i.e.*, claims for small amounts but involving relatively high adjustment cost.
6. Underinsurance.
7. Complex adjustment problems due to partial overlapping of different policies.[1]

The safeguard against the first of these dangers is precise definition of the risk assumed, which often requires specification by exclusion. Examples are the clauses in fire-insurance policies eliminating loss by theft and loss by explosion. Similar exceptions are found in other policies.[2]

Less can be done in drafting forms to safeguard against moral hazard. The unusual form of the hail policy is partly dictated by this consideration. Attention was called on page 150 to language inserted in the livestock policy for this purpose.

The resumption clause in the use-and-occupancy forms, the reference to failure to harvest in the hail form, and exceptions 3 and 4[3] of the livestock policy are examples of efforts to reduce the hazard of a poor morale in these respective lines. But, as has been indicated, such hazard cannot be entirely eliminated.

The nature of the provisions that must be inserted to reduce adverse selection is illustrated by the provisions as to premium payment and cancellation in the riot-and-civil-commotion policy,[4] by the second item mentioned in the discussion of the hail policy,[5] and the requirement that the rain-insurance policy must be applied for a week in advance.[6]

The evident safeguard against nuisance claims is the use,

[1] See reference to nonconcurrent fire policies on p. 85.

[2] See descriptions of forms given elsewhere in this book and forms reproduced in the Appendices.

[3] See p. 151.

[4] See pp. 143–144.

[5] See p. 145. If this clause were not in the policy, insurance might be procured when the appearance of characteristic clouds presaged the approach of a bad hail storm.

[6] See p. 147.

either by insertion in the basic form or attachment in a rider, of a deductible clause, *e.g.*, the memorandum clause in the marine policy. Likewise the insertion in the policy or attachment by rider of an average or coinsurance clause is a safeguard against underinsurance. The reader will find several instances of the use of each of these clauses in the forms reproduced in the appendices or heretofore described.

The safeguard against complex adjustment problems is similar to that against assuming an unintended risk, *viz.*, a careful definition of the risk assumed. There is, however, this difference: the company may be willing to assume the risk, provided it is not wholly or partly covered by another type of insurance. For it is only in that event that the complexity may arise. Reference has already been made to the use of schedule forms for covering multiple-item risks.[1] Another example of such a precaution, this time in the policy, is found in the windstorm policy in the provision defining its coverage on the glass in the building and the specific reference to other insurance that might also cover the glass.[2] The treatment of the liability coverage under the boiler policy[3] is an instance of a different type of provision to accomplish the same purpose as well as to give the insured, and not other insurers, the major benefit of his policy.

Line Limits.—The problem of line limits, that of avoiding an excessive exposure to a single hazard, is very complex, involving consideration of the financial position of the company and the largest amount of loss which could be met at one time without injury, as well as the likelihood of several individual risks being involved in the same loss. For example, to a company with a surplus of but $50,000, a loss of $75,000 at one time would cause an impairment of $25,000 in the capital. But if the company had a surplus of $500,000 or, as some have, of $5,000,000, the loss would be less serious. In the latter case it would be scarcely noticeable. Such a loss might readily occur to a company not writing more than $5,000 on a single risk if 15 of its risks were involved in the same disaster.

In order, then, to protect the company in this respect, it is

[1] See p. 85.
[2] See p. 145.
[3] See p. 154.

necessary that dual limits be set, one, of the amount to be taken on a single risk, and a second, of the amount to be taken in a given risk region, meaning a group of individual risks that may be involved in the same event. Both must be set with regard to the capital and surplus of the company. In fixing the individual-risk limit, consideration must be given to the probable amount of insurance likely to be sought. The law of large numbers applies only to frequency of occurrence, and it is a matter of indifference which of a group of individuals exposed to a given risk incurs a loss. But if a large sum is risked on one policy, *e.g.*, $100,000, and only a small sum on each of the others, perhaps $5,000; when the large risk fell in, the loss would be the same as though a total loss had been experienced on each of 20 others. Any appreciable risk in excess of the average of the class tends to an unsatisfactory result, though a company with an adequate surplus may safely take the risk. If the departure of no one risk from the class average is great, the danger is less serious. Such chance of bad fluctuation as is then found is involved in the concurrence of many losses, not inaptly described as a *shock loss.*

In modern life insurance, shock losses rarely occur. Conflagrations do occur, and fire-insurance underwriters maintain careful conflagration line limits. To this end, cities are subdivided into districts as indicated by the natural fire breaks. Maximum limits are fixed and rigidly adhered to for each district, and usually for each block and building within the district. Careful records are kept of the risks taken in such areas to make sure that the limit is not passed.

The nature of workmen's compensation insurance is such that the companies can set no limit to the amount of any one policy, and a catastrophe, such as a boiler explosion or fire, even in a small risk, may cause large losses. The statutory limit which many states set on the amount that may be exposed on a single risk (usually an arbitrary 10 per cent of capital and surplus) does not apply. In this, and other cases, where the carrier must write, or desires to write, lines of insurance beyond its limits, resort is had to *reinsurance.*

Reinsurance.—In all lines of insurance the carrier, to satisfy field representatives, must often write a larger amount on a single risk than it can by itself carry safely. It may properly

do so by taking out insurance (reinsurance) payable to itself for the excess. Reinsuring is a very old practice and has, in recent years, attained a position of great importance, with appropriate developments in method.

In the early history of insurance, underwriters held quite rigidly to their own line limits, and it was the province of the insured or his brokers to procure a sufficient number of policies or the signature of a sufficient number of underwriters (in the case of Lloyd's policies) to give adequate protection on the property covered. But even under these conditions, a carrier or an underwriter might find a risk accepted which, when added to risks already covered, gave a total line exposed to a single event larger than good judgment dictated. One or more of the risks was then reinsured individually by offering it in whole or in part to other underwriters. If the risk was accepted, a policy was issued in favor of the direct-writing carrier.[1] The courts have held that the interest of the first carrier is an insurable interest. In all such cases the obligation of the reinsurer is to the direct-writing carrier only; the original insured is not in any sense a party to the reinsurance contract.

This practice is still resorted to on occasion but it is slow, cumbersome, and expensive. It may result in loss if the event insured against occurs before the reinsurance policy is obtained. The practice has, therefore, grown up of providing reinsurance facilities in advance of need by contracts or *treaties*. Such contracts are issued by carriers that do a direct business but, beginning in Germany in the latter part of the nineteenth century, a considerable number of companies have been formed to write reinsurance exclusively. There are now several such American companies, as well as European companies that maintain branches in the United States.

A number of forms of treaties for covering individual risks have been, and still are, in use. They fall into three classes:

1. Facultative.
2. Automatic:
   a. Excess.
   b. Quota-share.

In addition to such reinsurance, which is common to all classes of

[1] The carrier contracting with the original insured.

insurance, carriers writing workmen's compensation and other lines subject to shock losses, take *catastrophe* reinsurance covering excessive losses which may run beyond treaty or other reinsurance limits.

The *facultative treaty* is the first departure from seeking separate reinsurance of individual risks. Under it the reinsuring and reinsured carriers agree to a form in which risks, premium terms, commissions, and other details are to be submitted. The direct-writing carrier is not bound to submit for reinsurance any particular part of its business, nor is the reinsurer bound to accept, though sometimes it is provided that the reinsurer is bound from the time of submission unless it rejects. The chief advantage of such a treaty is the avoidance of the necessity in the first instance of "shopping around," though that may become necessary if the submission is rejected. It also avoids the expense of issue of separate policies since memoranda data coupled with the treaty serve the same purpose.

The *automatic treaty* of the excess type differs from the facultative in that the direct-writing carrier binds itself to *cede* all or a certain portion of the excess of each risk accepted over its own net line as set up in the treaty, and that the reinsuring carrier binds itself in turn to accept such cessions. The treaty provides for periodic accounting by *bordereau*[1] and for settlement of accounts. Usually the reinsuring carrier allows a commission to the direct-writing carrier, covering its share of the acquisition and other costs and taxes. Small losses are usually accumulated and settled periodically, but the reinsurer is drawn upon for larger losses because it would put too much burden on the direct-writing carrier to wait for the periodic adjustment. A carrier may have several excess treaties with different reinsurers covering several successive lines each equal to, or a multiple of, its own net retention. Sometimes the reinsurance above the net line is pooled pro rata among several reinsurers with whom the direct-writing carrier has treaty arrangements that so stipulate.

The *quota-share treaty* binds the direct-writing carrier to cede, and the reinsuring company to accept, a fixed proportion of each risk written by the former. This form of reinsurance is

[1] This is the technical term for a list or statement of policies issued, amounts reinsured, and other particulars called for by the contract.

less used as an underwriting tool than as a means of arranging the financial affairs of a new and small company so that its growth and development do not involve too much strain on its resources. It permits larger acceptances than would otherwise be possible. It is most frequently used by the smaller companies of an associated group under common management to satisfy their agents and increase the spread of business of the parent company.

A further development of this practice is found in an arrangement among the company members of a fleet under common management, usually also having a large element of common ownership. A contract is entered into among the several companies under which 100 per cent of their direct writings are automatically and immediately ceded to the largest company of the fleet. That company, after procuring such outside reinsurance on individual risks as its underwriters deem necessary, apportions the remainder among the fleet members in fixed ratios. For example, it might retain 50 per cent, a second company might receive 30 per cent, and two others 10 per cent each. In some cases the smaller companies are in effect only agencies, the parent company taking over their entire business and giving them an appropriate share of its underwriting profits, if any.

Detailed bordereaux are not usually used in connection with quota-share reinsurance. Intercompany accounting in such transactions is by way of gross totals.

Catastrophe reinsurance does not require reporting of individual risks, since, in those kinds of insurance which are subject to catastrophe losses, even a small risk may occasion such losses. For example, a panic among the employees of a relatively small office might cause a number of deaths or permanent disabilities for which the compensation required of the carrier would be $50,000 or more. A treaty covering catastrophe reinsurance usually binds the reinsuring carrier to reimburse the direct-writing carrier for that part of its loss on any catastrophe in excess of a stipulated amount, *e.g.*, $50,000. The reinsurer may then be liable up to an amount provided in the treaty, *e.g.*, $200,000. Under a treaty with these limits the direct-writing carrier stands all loss on any such event up to $50,000. It will be reimbursed, if the loss exceeds $50,000 for the full excess,

unless the total loss exceeds $250,000, but will not be reimbursed for the excess over $250,000. The limits chosen for such reinsurance must be set by the underwriters for the direct-writing carrier with due regard to its business and resources. The premium to the reinsuring carrier under such a contract is usually a percentage of the premiums of the direct-writing carrier.

Often catastrophe reinsurance is carried in a pool of carriers substantially along the lines of interinsurance. Sometimes such a pool will also furnish reinsurance to carriers not members of the pool, dividing the profits among the underwriting member carriers, *i.e.*, the pool acts as a proprietary reinsurance carrier.

Whatever the arrangement for reinsurance may be, the aim is the same, to permit the company to serve its customers with the full insurance they desire, and at the same time to protect the company from loss due to concentration of amounts of coverage exposed to single occurrences.

SUMMARY

1. The underwriting objectives of insurance carriers in all branches of insurance are

- *a.* To get a safe distribution of risks,
  - (1) By avoiding adverse selection.
  - (2) By securing an adequate volume.
  - (3) By avoiding congestion or concentration of risk.
- *b.* To get risks of a profitable type within each class.

2. The preliminary work to this end must be done in the field, and the agents must be governed by

- *a.* Instructions as to type of risks desired and those to be avoided.
- *b.* Instructions as to line limits.
- *c.* Provision for meeting the exceptional case.

3. The work of underwriting is based on the representations of the insured, supplemented by appropriate data secured by the carrier from other sources.

4. The mode of underwriting selection depends on the practice in issuing policies. It may depend on the following:

a. Rejection of application or offering of a different contract.
b. Notice to agent not to renew particular policies.
c. Cancellation of policies already issued as provided in the policies.

5. The underwriter cannot ignore competitive conditions, and often his freedom of action is thereby much restricted.

6. The underwriting staff participates in the drafting of forms to reduce underwriting problems to a minimum.

7. A most serious problem of underwriting is the maintenance of suitable line limits.

8. In order to maintain such limits, and yet permit agents adequately to cover the risks of their customers, resort is had to reinsurance.

9. Several systems of reinsurance contracts have been developed to meet the needs of the carriers in this respect, many of which are written by companies whose exclusive field is reinsurance.

10. Shock or catastrophe losses constitute a problem calling for a special type of reinsurance.

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CHAPTER XXII

ADJUSTMENT OF LOSSES

In one sense an insurance carrier may be regarded as a trustee for its policyholders, since it is from them it receives the funds out of which losses are paid. If an individual carrier habitually overpays its losses, it jeopardizes its own future. If all overpay, rates must be increased to provide sufficient funds. Underpayment defrauds the individual policyholder concerned, tends to bring deserved condemnation on the company practicing it, smirches the record of the insurance business as a whole, and leads to a general mistrust of both insurance carriers and agents. The carriers have a difficult course to steer between Scylla and Charybdis. And the difficulty of the passage is enhanced by the troubled waters of the adverse psychological attitude of the insured, except in the case of those branches of insurance, such as life insurance, where the policies are all valued and only total losses are encountered.

Obviously the insurance company has need of a suitable department for dealing with policyholders presenting claims for losses. Not only has it need for such a department, but the need is for a staff of unusual capacity in its knowledge of insurance principles and policy provisions, and in its ability to understand human nature and deal fairly and firmly with many different types of persons.

Technical Provisions of Policy Contracts.—In the several chapters of Part II, the technical provisions of the common forms of policies with respect to settlement of losses were outlined. These provisions determine the procedure for loss settlement. In general, the procedure must be initiated by the insured with some form of notice to the company that a loss has occurred. Usually, in practice, this will be given personally by telephone, or by note to the agent or broker through whom the policy was obtained. Few policyholders read their contracts

before a loss occurs. If they do so then, they learn for the first time their precise rights and duties, often to their surprise and dismay. Only in the case of the large loss to a corporation having competent insurance advice is it to be expected that the insured will follow precisely the policy provisions. Unless there is clear indication of fraud, public sentiment will not tolerate a hypertechnical attitude of the carriers. It, therefore, becomes necessary for the companies to make every reasonable effort to assist the claimant in preparing and presenting his claim. Since local agents are in many respects independent businessmen depending upon friendships and satisfied customers for their success, they are naturally disposed to furnish such assistance. If, in so doing, they carefully bear in mind their obligation to their companies, much good may result. In view of the doctrine of waiver and estoppel referred to below, much damage may result if the agent is not so mindful of his obligations to his company.

Mechanics of Claim Settlement.—In a well-organized company the receipt of a notice of loss initiates a systematic procedure designed to bring about settlement as promptly and with as little friction as possible.

The first step in such procedure is "checking for coverage." The company's records are examined to ascertain

1. That the policy under which the claim is made was properly issued and put in force by a suitable settlement for the premium, not necessarily always in cash.
2. That the policy was still in force at the time of the alleged loss.
3. That the claimant is the person entitled to claim under the policy. He is often someone other than the nominal insured, *e.g.*, a mortgagee under a fire-insurance policy, an employee under a workmen's compensation policy, the beneficiary or an assignee under a life-insurance policy.
4. That the property (under a property-insurance policy) is that covered by the policy.
5. That the hazard stated to have caused the loss was contemplated by the policy.

If the claim is apparently valid in view of these tests, formal claim blanks are sent to the claimant or, if the amount is large, a representative of the company is put in charge of the case and

continues negotiations with the insured, checking the case for loss. This consists in ascertaining

1. That a loss has in fact been sustained.
2. The cause of the loss and all attendant circumstances, in order to determine whether it was covered by the insuring clause, and not barred by the exclusions in the policy, and whether the policy had been avoided by some action of the insured.
3. The actual amount of loss sustained, *i.e.*, the value of the loss.
4. Whether anyone other than the claimant, against whom the company may obtain a claim by subrogation to the rights of the claimant, was responsible for the loss.

These four duties, particularly the ascertainment of the values involved, constitute the difficult part of loss adjustment.

Psychological Attitude of Claimants.—In most classes of insurance the difficulty of loss adjustment is enhanced by an adverse psychological attitude on the part of claimants. As already noted, few policyholders read their contracts in advance of an occurrence resulting in loss of the type that they assume the contract covers. Consequently, many invalid claims are presented in entire good faith. Even when the claimant, after conference with adjusters, admits that the claim is not justified, he often feels aggrieved at the company, either for putting into the contract what now seems to him improper restrictive clauses or for permitting the agent to misrepresent the contract. For, whatever the fact as to the fairness of the restrictive clause or the fullness of warning by the agent, the claimant whose claim is not recognized is an emotional rather than a reasonable being. Free recognition of such claims is, of course, improper, because the company that recognizes them in large numbers jeopardizes its own solvency on which the protection of other policyholders rests and, if it does not injure itself permanently, tends to raise the cost to the public, because it is only from premiums assisted slightly by interest earnings that losses and expenses can be paid. Refusal to recognize such claims gives the company a bad name for hypertechnicality. Those in charge of loss settlement must, therefore, weigh carefully the loss involved in recognizing such claims against the loss involved in the creation of adverse criticism.

Not only is the attitude of the claimant often adverse in this

regard, but it is also adverse as regards valuation of property. He feels the purpose and intent of insurance is, so far as possible, to put him back in the position in which he was at the time of the fire, or other cause of loss. With that view there can be no quarrel. In practice, it is rarely possible fully to realize it. Consider, for example, a loss by fire in which household furnishings have been in part destroyed and in part badly damaged. It may be assumed for purposes of discussion that the furniture was well made, is about 5 years old, and has been well cared for. To its owner it has many years of useful life. He has become attached to some pieces so that there is an additional sentimental value, but he will usually waive that as not replaceable. Repairs, if well done, he accepts with fair grace. The repaired pieces look fairly well. Perhaps the history of damage is not traceable in their appearance, but he knows it and the edge is dulled. But those pieces that are destroyed! The amount payable under the policy is their replacement cost new, less depreciation. True he could not have sold them for what they originally cost. But he had no desire to sell. He needs the same kind of things. He can get them for the amount payable for his loss, only by buying secondhand stuff. He does not want some one's else castoffs. He has to suffer all the inconvenience of renting another apartment until his own is restored. He has to find new things. It is very difficult, indeed, for him to feel that he has received what he thought he paid for, when he is paid a cash sum equal to the value of his goods and must himself attend to replacement. He, or if not he, surely his wife, would strongly resent the insurance company's barest hint of a desire to replace with secondhand goods. Let the reader try to visualize himself in the position of the claimant and then, in the role of adjuster, try to satisfy himself. The illustration has been taken from the fire-insurance field. The principle applies broadly to many others.

The difficulties above noticed have been encountered since the beginning of the practice of insurance. They have been met in various ways but, of necessity, there has been much reduction of claims. Of course, since full payment is the expected thing, the insured takes the full settlement of a fair claim as a matter of course. If inquiry is made, he will commend the

company but he makes no special effort to do so. But the claimant whose claim has been rejected or scaled down, unless he has been caught in downright fraud, is not loath to speak of it. He feels aggrieved and seeks the opportunity to impress the unfairness of the settlement on all who will listen. The result is a widespread belief that insurance companies do not pay, and do not intend to pay, the claimant what he asks, whether or not it is a fair measure of his loss; that it is the province of the adjuster to scale down claims; and that his compensation is based on the "salvage" he makes regardless of how he makes it. The natural defensive action under this impression is to pad the claim for the amount which it is believed the adjuster will try to cut it. Many an honest policyholder has put in an exaggerated claim in the belief that it was necessary in order to get his just indemnity. An example outside the field of insurance of the same attitude is the amount usually claimed as damages in personal-injury actions. It must be said with regret that there have been, and are, insurance organizations (stock and mutual companies and reciprocal exchanges), in dealing with which, exaggeration of claims is really a necessary measure of self-defense. But, certainly it is not necessary when one is dealing with companies of the highest standards, and it is the author's conviction, after many years of close contact with various branches of insurance, that it is not necessary with most of the well-established carriers.

In the above, downright fraud has not been considered. Any experienced claim adjuster can furnish abundant evidence of efforts of those who live by their wits to perpetrate fraud upon insurance carriers. The protection of the public from arson and like crime, as well as the defense of the treasury of the insurer, require that the claims of this gentry be rejected. But they are so skillful that they often collect; and the fear of the adjuster that the claimant who has obviously been overzealous in his own interest may be of this type does not make any easier the problem of meeting the adverse attitude of the honest claimant.

But not all cases of fraud are presented by habitual knaves, nor do many of them cause the same public condemnation and contempt as do most petty thievery and roguery. Whatever

the explanation, there is, in the United States at least, a widely shared view that insurance companies and other public-service corporations are "fair game." It is indeed a citizen with a rare sense of honor who will refuse to lend his neighbor his commutation ticket to go into town, unless he is afraid the user will be indentified and the ticket confiscated. And it is a rarer citizen who will decline the use of such a ticket. Yet such use is a clear violation of the contracts under which the tickets are sold and a fraud upon the railroad. In most circles it would be deemed clever to have secured payment of a claim against an insurance company for a few dollars, or a few hundred dollars, more than was justly due. "After all you did not find out that some of the goods listed were seconds, and would not command first-grade prices, that was up to him, not you," represents the usual attitude of the friends and acquaintances of the claimant.

Practical Needs in Loss Adjustment.—There is a popular impression that a loss adjustment should consist only in interviewing the claimant, identifying the property lost, and paying the claim. In some fields, *e.g.*, life insurance, loss settlement is almost as simple as that. Since the policy is valued, it is necessary only to ascertain that the insured is dead, which can be certified to by the attending physician; that the policy is in force, which will be shown by the company's books; and that the claimant is the beneficiary under the policy, which can usually be readily established. Consequently, life-insurance claims are often paid within 24 hours after completed claim papers are received at the home office. But, in general, an adjustment of loss is far more complicated.

Often, the first requirement is to stop further loss. This must be done, for example, where perishable goods have suffered smoke and water damage in a fire and where, if not dried out, rot will set in and cause further deterioration; or where a workman is injured and, if not promptly given first aid, may lose a limb or even his life, from infection. Under liability insurance, if the injured third party has time to brood over his injuries or fall into the hands of an unscrupulous shyster lawyer, his claim may be exaggerated. The illustrations given above suggest the means of prevention. Methods differ with the class of insurance and type of loss.

When steps have been taken to prevent further loss, it is necessary to consider *salvage.* Goods damaged by smoke or water can sometimes be reconditioned at slight expense, so that the claimant will be satisfied, and even pleased, to receive them back without further indemnity. Sometimes, as in marine insurance, extensive engineering operations are involved. In workmen's compensation insurance, a surgical operation may be indicated, or retraining for a new occupation. Sometimes, salvage may be obtained through an action against other parties, taken under a right of subrogation received by the carrier from the insured. Whatever form it may take, the means of obtaining the salvage must be secured before final settlement is made with the claimant. Salvage need not be converted into cash or its equivalent before payment can be made. If a suit against third parties is necessary, such conversion is impossible. But the goods must have been legally transferred to the company, the subrogation assignment signed, or such other action taken as is necessary clearly to procure for the company the benefit of the salvage.

The remaining need is a fair settlement in accordance with the spirit rather than letter of the contract. If the carrier insists too meticulously on technicalities, not only is an essentially unfair, albeit legal, advantage taken of the claimant but, in the long run, the reputation of the company and of the insurance business as a whole is injured. Niggardliness stands in the same category. On the other side, stands looseness in exacting proof of loss from the claimant. There are records of arsonists who have asserted that they were started on a career of crime by seeing how easily an unfair claim had been passed by a company representative who was not alert to his full duty.

Appraisal.—Many forms of policy provide for an appraisal of the loss in the event that the carrier and insured cannot agree on the amount of loss. Since the insured must stand half the cost of appraisal, this is a weapon in the hands of an unscrupulous adjuster to force a small discount on all claims. No respectable company will tolerate such a practice. Unnecessary appraisals are to be avoided as needless expense. But where the nature of the loss is such that otherwise the two parties cannot both be convinced that a fair estimate of the amount of loss has been

reached, there should be no hesitancy in resorting to the terms of the policy providing therefor. The most reputable companies take this view. Neither party should appoint as appraiser an advocate of his interest, but each should seek a person technically qualified and disinterested, who will take a professional pride in arriving at a fair estimate of the amount of the loss.

Replacement.—Most policies of property insurance give the insurer the right to repair or replace damaged property, taking the property for disposal. Replacement is very seldom resorted to, and making of repairs is rare. Either action usually involves substitution of new materials for old, giving the insured more than he is entitled to, and correspondingly increasing the loss to the company. Repairs are made in such cases as are controlled by a general rule providing an offset allowance for the greater value of the new material. Such a rule obtains in marine insurance.[1]

Waiver and Estoppel.—The doctrine of waiver and estoppel and its basis have been briefly outlined.[2] It is in connection with the adjustment of losses that the danger of running afoul of this legal doctrine is greatest. The adjuster is not so likely to commit himself in writing in such a way as to create a waiver, as he is to find that, either through his own action or that of the local agent or some other representative of the company, an implied waiver has been created which estops the company from insisting on some one or more of its rights. If the insured can make out a prima-facie case, showing that an action by a company's representative has led him to a line of action or inaction as a consequence of which he later finds himself unable reasonably to comply with the company's demands, whether or not they are in accordance with the policy, there is a high probability that a court would excuse him from complying with them, on the ground that the company had by implication waived its right of insisting on compliance. This has occurred despite a policy provision that no action of the company in investigating a claim or ascer-

[1] In the case of particular average to hull the rule is "thirds off," meaning that the insurer shall bear only two-thirds of the repair cost, the other third being borne by the owner. In the case of general average the old rule was "thirds off," but Rule XIII of the York-Antwerp Rules of 1890 provides a sliding scale dependent upon the age of the vessel.

[2] See pp. 80, 81.

taining the amount of loss shall be held to constitute a waiver of any of its rights. If there are likely to be difficult problems in a loss adjustment or need of immediate action, *e.g.*, prompt removal of goods to stop loss and begin reconditioning, the cautious adjuster will seek a *nonwaiver* agreement with the claimant under which both parties agree that the removal, or whatever other procedure is contemplated, does not constitute an acknowledgement of liability or a waiver of any right of either party. Such an agreement, though it is looked upon with suspicion by the insured, if properly drawn, is only fair as a means of establishing a *modus vivendi* pending determination of rights and liabilities of both parties.

Qualifications of Adjusters.—This brief outline of the essential problems of loss adjustment should have indicated that, for the successful handling of this work, the carriers require men with special qualification both of personality and of knowledge. Probably the personal qualities are the more important since, to a large degree, they must be native. The others may be acquired by training. The first personal quality required is affability and tact, the ability to meet all classes of people on their own ground. Although this quality is in part a native gift, it may be enhanced by liberal education, designed to give an understanding of people and of life. Next are required patience, thoroughness in investigating details, resourcefulness to uncover dishonesty, and open-mindedness to avoid prejudging cases.

The technical equipment necessary for an adjuster differs with the branches of the insurance business but includes, in all cases, a thorough knowledge of the policy contract and a working knowledge of the fundamentals of commercial law. Other technical equipment required will be better understood if considered in connection with the special problems arising in the several branches of insurance.

Special Problems in Particular Fields. *Fire Losses.*—Incendiary losses are rare, and there are not many cases where the company will be excused from liability by reason of the cause of the fire. But the cause should always be sought and fully noted in the report of the adjuster, because of the value of the information to those engaged in prevention work. All too often fires destroy the evidence of their causes. The greatest problem in the

adjustment of fire losses is the ascertainment of value before the fire and after the loss. This may involve accounting work to determine the stock on hand, and the working out of profit ratios and ascertainment of discounts and other terms, in order to convert gross sales as shown by the account books into net value on a purchase-cost basis, the latter again to be put on a current market basis. Engineering problems may be involved in the salvage and reconditioning of stock or machinery, or in reconstruction and rehabilitation of buildings. The adjuster may call upon accountants and engineers as needed, but he should be able to handle the simpler cases himself.

Theft.—In theft insurance, substantial damage losses do not often arise to plague the adjuster. There may be a small amount of damage done by the thieves in breaking into and ransacking the premises, but this is not the major problem. If it is a clear case of burglary, the main problems are to identify clearly the stolen property, to apprehend the thief, and to recover as much of the property as possible. Sometimes this could readily be done at reasonable cost, were there no danger in so doing of compounding a felony. Here, as in suspicious fire losses, it is wise to maintain cordial relations with the police. If the case is not one of burglary but is covered under a broader policy, the major difficulty is to keep clients satisfied and yet not pay for goods that have merely been mislaid. Many times companies have been reimbursed by the insured who has later found the "stolen" property. How many times they have not been reimbursed is another question.

Liability Insurance.—In liability insurance the greatest difficulty is to get the facts. Accidents happen (*e.g.*, a collision between two rapidly moving automobiles) in such brief intervals of time that few eye witnesses will agree on just what happened, even when they have no incentive to a prejudiced statement. Often they have a material interest or sympathy, which warps their view. When the facts, or the best representation of the facts obtainable, have been secured, the next problem is to see them as they will appear to a jury when drawn from the witnesses under the circumstances of a trial. The chance of the verdict being against the insured, and the probable amount, must then be weighed. And there is little time available for this, since wit-

nesses may disappear and claimants exaggerate their views if delay ensues. There is, of course, danger of increasing the amount claimed, if it appears that an insurance company and not an individual will be called upon to pay. The insured is bound by his policy terms to assist in the defense of claims, but his assistance may be nominal, and his real interest to escape personal blame by seeing that the company makes a liberal settlement. Although some of the most reputable law firms handle damage-suit actions, such actions, on a contingent-fee basis, are the source of greatest profit for unscrupulous members of the bar. The kind of resistance to be encountered in defending cases must be considered. Sometimes it is possible to settle an uncertain claim for less than the cost of defense. These are known as *nuisance* settlements. This kind of settlement must at times be made, but they are dangerous, for they encourage the *ambulance-chaser* type of lawyer.

Workmen's Compensation.—Strange as it may seem, the problem of adjustments in workmen's compensation insurance is closely analogous to that of partial loss in fire insurance. Only in a few cases does a question arise whether the accident is covered under the compensation law. The first question is whether the injured is getting proper medical aid. The second is whether the doctor is padding his bill, for high as are the ethics of the medical profession as a whole, there are those whose attitude seems to be that, since an insurance company will have to pay the bill, it might as well reimburse also for some of the uncollectable bills or gratis services that have been rendered to others. The third question is when has the injured so far recovered that he should return to work, and what is the degree of permanent disability, if any. How much real malingering there may be it is hard to say. The author believes that many are inclined to overestimate it. Often the best treatment to avoid permanent stiffness, after an arm, for example, has been injured and partly recovered, is regular exercise and light work. But it hurts to do this, and the injured naturally shrinks from the pain and effort. In various ways he must be induced to make the effort. It may be necessary to find him a job suited to his limited capacity. It may be necessary to consider offering rehabilitation training, and perhaps to induce the injured man to

take it. Occasionally it has been found profitable to all concerned to pay liberally for his support and that of his family during retraining, in order to avoid a large pension for life on account of reduced earning power. Sometimes difficulty is encountered in inducing a man to accept operational treatment for certain injuries, and the assistance of the industrial commission may have to be sought to that end. Cases of occupational neuroses are particularly difficult to deal with. There can be no set rule for handling such cases. It is all-important for the carrier to secure, and keep, the good will of the industrial commission of each state in which it operates. Although the care of the injured is their first interest and duty, and the commissions are faithful to that duty, and although it should not be inferred that they are disposed to carry grudges, yet, in many borderline cases or cases of real malingering, a reputation with a commission for fair, nontechnical handling of cases is of great value to the carrier.

Personal Accident-and-health Insurance.—Most of the classical instances of fraud, malingering, and self-maiming are drawn from the experience of the companies writing personal accident-and-health insurance. The most flagrant cases of defrauding of claimants by badly managed claim departments have also been found in this field. Perhaps the two facts are not unrelated. There is the same problem of medical aid as in workmen's compensation insurance, though the policy contracts do not always provide for medical aid. The adjuster needs, as in industrial-injury cases, an understanding of medical terms and practices. For a company whose aim is the faithful carrying out of its contracts and fair treatment of policyholders, the principal problem is the determination of the integrity of the claimant. If he is seeking no more than he is justly entitled to under his contract, no great difficulty is encountered in settling with him. If he is attempting a fraud, it becomes a battle of wits, the adjuster seeking to catch him off his guard and make him expose himself.

Automobile-theft Insurance.—Automobile-theft cases present some novel features not found in other classes of insurance, except perhaps residence burglary and theft insurance. It is often difficult to prove or disprove a claim that a car was stolen. If the car was insured for a named sum, even though not on a

valued policy, the insured may think that sum is recoverable in event of theft. When sudden depreciation becomes evident, he may seek to "sell it to the company" at the policy value through a theft claim. There have been fished up from the waters surrounding some of the big cities cars that were obviously disposed of to make way for a theft claim.

In most cases of real theft the car is recovered, usually abandoned by the thieves in more or less damaged condition. Once convinced that the car has been stolen, the adjustment staff must try to satisfy the insured and secure a reasonable time to try to recover it. Failing that, the claim must be paid, but effort to recover the car continued. If the car is recovered, it must be reconditioned and sold so as to net the largest possible salvage to the company.

Surety Bonds.—The great variety of risks covered by surety bonds precludes any general statement with regard to loss procedure under them. When a contractor appears to be in trouble on a contract, the surety company may advance him money, furnish engineering service, or even, with the consent of the obligee, take over and complete the contract. Under other types of surety bonds other procedures may be indicated. The type of loss most resembling insurance losses is that under a personal fidelity bond. This case is much like a loss under a burglary policy. The obligee must be indemnified and an attempt made to recover the stolen property. The case, however, is different in this respect, that the property taken by a burglar is all taken at one time and, unless promptly disposed of by him, may be recovered at once. Further, it may be identified, and the attempt to dispose of a part of it may lead to the apprehension of the thief and the recovery of the remainder. But the peculations of the defaulter have usually extended over a period of time and been lost in gambling, speculation, or fast living. Hence, recovery is improbable. On the other hand, the surety is only secondarily liable and may be able to recover from the estate of the defaulter. Sometimes the family or friends of the defaulter will make good his defalcation to hush up scandal. It is the district attorney who must decide the question of prosecution. The representative of the surety cannot, and should not, promise immunity if the defalcation is made good. He may

intimate that he will not press for prosecution. Unless the defalcation is made good, it is the policy of the surety companies to pursue the defaulter to the ends of the earth and to have him brought back for prosecution as a deterrent example to others who may be tempted.

Life Insurance.—Settlement of life-insurance claims is simpler than adjustments in any other field of insurance. Disappearance cases, which occur rarely, call for investigation, usually by the inspection department.[1] Occasionally, in case of divorce, it may be uncertain who is the rightful claimant. This is a legal question, and the legal department of the company will take charge. If the amount is large and the case uncertain, the proceeds of the policy may be paid into court under an interpleader action, leaving it to the court to decide which of two or more claimants is the rightful beneficiary.

There have been cases of fraud, usually of misrepresentation by an applicant of habits in regard to liquor or of physical defects, but under the incontestable clause these cases cannot be contested after the time limit provided by that clause has expired. As the time limit cannot exceed 2 years, these cases are also rare.

The introduction of a permanent-total-disability clause into the policy brought in a new type of claim which has saddled the claim departments with more work, and work of a different kind. The major problem presented is what constitutes permanent total disability. Most policies now provide that 120 days of total disability constitutes presumptive evidence that the disability is permanent. This has disposed of the question of permanency, merely requiring periodic check to establish continuance of total disability.

The introduction of increased benefits for accidental death has also, but not to the same extent, tended to complicate the work of the claim department. During the depression the companies were confronted with many claims under the double-indemnity clause where the insured died from carbon monoxide poisoning. He was found in his garage with the doors closed on a cold morning and the engine still running. Perhaps his business affairs were in bad shape. Was it an accident or was it an effort

[1] See p. 389.

to provide for his family by his death what apparently he would not be able to provide in life? Even though the period during which suicide is a defense against a claim for the face of the policy has passed, the beneficiary is not entitled to the doubled benefit unless the death was caused by accidental means. Did or did not the policyholder know the danger of warming up the engine in the closed garage? Did the door blow shut? The claim department must decide in such a case whether the evidence of suicidal intent is strong enough to justify refusal of the larger sum and fighting the case in the courts, if necessary, or whether it is better to forget suspicious circumstances and to pay promptly. If such a case is taken to court, the legal presumption is always that the cause of death was accidental. In the same class is the case of falling from a window.[1]

Miscellaneous.—In the foregoing discussion of special problems in loss adjustment no attempt has been made to deal exhaustively with all kinds of insurance claims. From what has been said and from a careful study of the policy forms involved, it is believed that the reader can picture for himself the important claim problems in other fields.

Independent Adjusters, Public Adjusters.—In addition to staff adjusters employed by carriers, general agents, and adjustment bureaus, there are *independent adjusters* and *public adjusters*. Independent adjusters[2] may be experts in particular types of adjustment, *e.g.*, marine general-average adjusters, or they may cover several lines. They may be employed on particularly difficult cases or called in when the volume of work to be done is too great for the regular staff.[3] The business of independent adjusters in liability lines, especially automobile liability, is increasing because of the scattered character of the cases.

Public adjusters offer their services to the insured. Because of the harm that may be done by unqualified and dishonest persons acting in this capacity, several states require that before one may practice as a public adjuster a license must be procured from the

[1] The companies now regularly exclude death due to inhalation of gas from the coverage of the double-indemnity clause.

[2] It seems to be becoming a fad to spell the word "adjustor."

[3] At the present time of man-power shortage in all lines they are particularly busy.

state insurance commissioner. It is usually required that, before such a license may be granted, the applicant must pass an examination designed to test his capacity, and the commissioner must be satisfied that he is of good moral character.[1]

SUMMARY

1. In the settlement of claims, it is the duty, as well as to the interest, of the carrier to pay their full obligation but not to overpay. This often involves a delicate balancing of rights.
2. The terms of policy contracts lay down the technical limits of liability and loss procedure.
3. The mechanics of claim settlement involve

   a. Checking for coverage to determine whether
      (1) The policy is in force.
      (2) The claimant is covered.
      (3) The property and hazard are covered.

   b. Checking for loss to determine
      (1) Whether a loss was actually sustained.
      (2) The cause of the loss.
      (3) The amount of the loss.

The (*a*) checking may be done in the office. The (*b*) checking must be done in the field.

4. The carrier must secure its right of subrogation and other salvage, if there be any, in order to reduce the net loss.
5. Often the psychological condition of the claimant makes it difficult to deal with him, for

   a. He usually has not read his policy and does not understand his rights and duties.
   b. He usually overvalues his property for sentimental reasons.
   c. He usually suspects that the company does not intend to pay in full and pads his claim for trading purposes.
   d. He often thinks that the company is fair game and that he should get what he can, perhaps having carried his insurance a long time with no loss.

[1] In New York, independent adjusters are required to obtain a license.

6. The functions of an adjustment are

   a. To stop further loss and damage.
   b. To secure all proper salvage.
   c. To settle fairly without
      (1) Injuring the company's reputation by over insistence on technicalities.
      (2) Injuring the company's reputation by niggardliness in valuation.
      (3) Encouraging fraud and crime by laxity.
      (4) Incurring undue trouble and expense by needless appraisals.
      (5) Making replacement of new for old without due allowance for depreciation.

7. One great problem in loss adjustment is to avoid forfeiture of company rights through implied waiver and consequent estoppel.

8. Adjusters for carriers must be skillful in meeting and dealing with all types of people, technically versed in the policy terms, and familiar with the properties and risks insured.

9. Special conditions of the several types of insurance coverages differentiate the problems of loss settlement under them and call for special knowledge and procedure on the part of carrier representatives.

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CHAPTER XXIII

INSURANCE FINANCE

The insurance carrier, whether stock company, mutual company, or reciprocal exchange, is a financial institution. The financial aspect of insurance-company management, and its associated accounting and investment problems, are of major importance in any comprehensive consideration of the insurance business.

Collection of Premiums in Advance.—In a small community or other closely knit group it is possible to furnish insurance by a pure assessment carrier, to defer collection of the funds for loss payment until after the loss occurs, and to carry no funds in the organization. But even in such a community the question might well arise whether a particular claimant was entitled to benefit unless he had already contributed on several other claims. There might also often be uncertainty as to the ability of all in the group to pay their full share, assuming complete confidence in their willingness. Even if these questions did not arise, there still would remain the delay in paying the claimant, which would be necessary to allow time for collection. Even the assessment carriers, therefore, usually assess in advance to provide at least enough to meet one claim and pay running expenses. Stock or mutual corporations, or reciprocal exchanges, regularly collect advance premiums, or deposits, to cover the probable loss during the term of the policy, or other fixed period, even though the policy may provide for assessments.

Premium Not Earned until Service Performed.—Premiums paid in advance, though legally the property of the company, have not been earned, for no service has been rendered. In the absence of statutory provisions it would seem that the carrier has the legal right to use these premiums as it pleases. But the policyholders have a claim against the carrier for the services for which the premium was paid. Therefore, quite independent of statutory regulation, a carrier that scrupulously regards

its contractual obligations, and desires to preserve its own reputation, must so arrange its financial affairs as always to be able to meet just claims against it. This means that it must regard some part of the premium received on each unexpired policy as unearned until the policy has expired. What part is this? What is the significance of this view?

As was pointed out in Chap. X, the probability of death within 1 year depends on the age of the insured and increases with his age, so that a part of the level annual premium charged for life insurance is in excess of current requirements for mortality. Clearly this part is unearned, even at the end of the policy year. The same condition obtains in noncancelable accident and health insurance, the risk of disability increasing with age, and the premium charged being level and fixed on the basis of age at entry. But in the year for which the premium is collected, the deaths and disabilities do not occur at the beginning of the year. In fact, in the actuarial calculations, they are assumed to take place at the end of the year, and the company is not considered to have earned the net premium until that time.

Deaths and disabilities in a large group are fairly evenly distributed over the year. And this is true also of fires and other casualties against which insurance is offered.

It is, then, fair to say of that part of the premium designed to pay current losses that it is earned pro rata as the term of the policy passes, and that the part corresponding to the unexpired portion of the current term, and all amounts charged in anticipation of losses to occur after the expiration of the current term, are unearned.

As to the part of the premium designed for the payment of expenses, the situation is not so clear. If the carrier is to pay future losses, it must continue to be a going concern. There will be future expenses to be met, and the money required for them should not be spent until so required. But the largest item of expense in respect to any individual policy, the commission payable to the agent for securing the business, is incurred when it is issued. This must be spent at once. As a matter of fact, in those kinds of insurance where the policy is issued and the premium collected by the agent, this part of the premium is never received by the carrier.

But if a portion of the premium is unearned, does it belong to the policyholders? Is it a trust fund? Or can it be commingled with the company's other funds? The statutory provisions dealing with these questions will be discussed in Part V. At this point it is well to try to reach a conclusion on the basis of sound business practice, public interest, and contract provisions.

If claims that arise need not be paid immediately, it is not necessary to hold cash funds to meet them. In general, claims are not immediately payable on notice of the occurrence of the loss causing the claim. Determination of the question of liability and the amount of loss, as explained in Chap. XXII, usually takes some time, and the policy contract often allows a period of time to elapse before payment is required. In several kinds of insurance, loss payments are spread over a period of time. For such payments, investments that can be converted into cash within a reasonable time will meet the need of the carrier quite as well as cash. It is to the disadvantage of the public to lock up large amounts of funds in hoarded cash. Invested funds are more productive.[1]

The individual policyholder's premium is ordinarily payable in cash, and the contract makes no provision for payment to him other than in cash, though the company may make other settlements which will involve it in cash outlays, *e.g.*, repairing, paying court costs, etc. So long, therefore, as the cash is available when required to liquidate his claims there is no reason why these unearned premiums, or the investments that represent them, should be sequestered and kept apart from other funds of the company. Neither statutory regulation nor business practice so requires. But it is evident that policyholders have an equitable right to some part, if not to all, of these funds.

Not only have the policyholders an equitable right to unearned premiums, but they have a contractual claim to them in almost

[1] In the normal course of business, income received during a calendar year is more than sufficient to meet the disbursements of that year. There is usually, therefore, no necessity for liquidating investments in order to provide funds for payment of losses and expenses. But the carrier should always be in a position to meet its obligations without reliance on income other than that received for undertaking the specific obligations to which given income relates.

all cases, for the policies in most classes of insurance provide for cancellation at the option either of the policyholder or of the carrier. Life-insurance policies carry specific surrender values, and other forms of contract usually provide for the retention of an earned premium for the period covered, computed by a short-rate table if the cancellation is at the option of the policyholder, while the full prorata unearned premium is payable to the insured if the cancellation is at the option of the carrier. Such equitable rights do not create liens upon specific investments or handicap the financial transactions of the carriers, but are properly cared for by recognition of the gross amount of the policyholders' equities as a liability, and the holding of suitable investments equal to, or greater in value than the liability. This is both the legal requirement and regular practice. These balance-sheet liability items are known as "reserves."

Function of Capital and Surplus.—In contrast with manufacturing, transportation, and merchandising enterprises which require more or less physical capital in order to function, financial institutions require very little. An office, often rented, in which to transact business, suitable furniture, and other office equipment, and records which are of value only so long as it is a going concern, but of little more than junk value if it ceases to do business, are all the physical equipment required. Yet financial institutions have capital and surplus funds, paid in or earned, in addition. Not only do they have capital and surplus, but usually they are not permitted by law to begin to operate until the capital has been paid in cash. What is the purpose of such a requirement? The key is found in the further requirement that the capital be maintained unimpaired over and above all liabilities. This clearly indicates that the purpose is to maintain the credit of the institution, to provide a bulwark against loss for the benefit of all who may do business with it, whether the institution is a bank, a trust company, or an insurance carrier. But, as it is a secondary defense, only to be called upon when the obligations cannot be met from the proceeds of other assets, it need not be in cash. On the other hand, it must be represented by something that can be converted into cash should the need arise. Valuable as an extensive agency plant may be, it cannot serve as a part of the capital of a company since its value will vanish when the

company ceases to be a going concern. No good-will value can be used as a part of the capital of an insurance company. A company must, as has been shown, have an agency organization, and time and expense are required to build it up. But this expense must be met out of the earnings of the business or the contributions of the stockholders, and charged off.

For this reason it is always desirable, and usually required by statute, that the stockholders of a newly organized insurance company pay in a surplus, through buying the stock for more than its par value. What proportion the surplus should bear to the capital depends on the conditions under which the organization takes place and on the plans for development. Experience indicates that it should not be less than 50 per cent, and preferably 100 per cent or more of the capital. Experienced and skillful managements endeavor to keep a substantial margin of surplus to take up the shocks of variation in experience from year to year, so as always to keep the capital unimpaired.

Importance of Investments.—The asset side of an insurance carrier's balance sheet will thus consist of investments, cash in office and bank, premiums in course of collection and in transit, and such fixed assets as furniture, fixtures, and supplies. The more conservative companies take no credit for the last three items; if they are listed as assets, they are deducted as "not admitted" by the state authorities in publishing their reports. Real estate, if owned, is considered an investment; office premises can almost always be sold, since they are readily adaptable to the use of others without much expense.

From the foregoing discussion it is apparent that its investments are of the utmost importance to the insurance carrier. Since the premiums collected from individual policyholders are relatively small, insurance carriers constitute collecting reservoirs for investment funds. Some students regard this aspect of the business as of importance almost on a par with the service of eliminating risk. Indeed, some writers stress the accumulation of capital in advance as an essential characteristic of insurance. The present writer cannot go so far. The great social-insurance institutions of some of the European governments show rather conclusively that, under proper conditions, the service of eliminating risk, the real insurance service, can be performed without

advance accumulation and investment of funds. If attention is confined to the commercial practice of insurance, the advance accumulation of funds is a practical necessity; the serving as collecting reservoirs, of great public advantage; and proper investment of funds, of prime importance.

Not only is it socially desirable that funds be invested in order that they may be productively employed, it is also desirable from the standpoint of the carrier, since the investment yield may serve either to reduce the cost of the insurance to policyholders or to furnish profits to the stockholders. The investment yield is especially important in life insurance. There, as explained in Chap. X, the risk is one of time of occurrence, and the present value of the future payment depends on the earning power of money. A certain interest yield is assumed in the actuarial calculation of premiums and reserves and, if this yield is not realized, the rates and reserves will prove inadequate, and the company will be unable to pay its claims.

Types of Investments Adapted to Needs.—Although insurance carriers of all kinds should invest all their funds, except such as are required in the current transaction of their business, the investment needs and proper investment policies differ according to the kind or risks covered. In this regard carriers fall into three types:

1. Those in whose business large emergency losses payable in cash within a limited time may arise. Examples of this class are fire- and marine-insurance carriers to which a single conflagration or series of storms may bring losses running into millions of dollars.

2. Those in whose business large losses may arise within a brief interval of time, which are not payable at once but in installments over a considerable period of time; *e.g.*, a company doing an extensive workmen's-compensation-insurance business may become involved in a single catastrophe that will cause losses running into many thousands of dollars, spread, however, over a term of years as specified in the compensation law.

3. Those not subject to any excessive loss from a single occurrence. Life-insurance companies are the chief examples of this class. Even the influenza epidemic of 1918 did not, in most cases, call for cash in excess of funds readily realized without sale of investments.

The exigencies which companies in the first of the above classes must be prepared to meet are such that a very considerable part of their investments must be in readily marketable securities, so that funds to meet an emergency may be promptly raised. This observation, however, is to be limited by consideration of the underwriting policy of the company. A sufficient amount should be kept in a form readily liquidatable to meet one case of the most severe loss reasonably to be expected. If there is a second set of investments that can be converted without undue delay, it would not be a sign of poor management if part of the assets were in a more permanent form, *e.g.*, the home-office premises. But in general a slow form of investment such as real-estate mortgages, particularly farm mortgages, regardless of the ultimate soundness of the underlying security or the rate of yield, should not form a large proportion of the assets of this type of company. And in American practice they do not.

Owing to the nature of its liabilities a company of the third type may well seek long-time or semipermanent investment. For this type, stability of yield with sound security is the first consideration. This is particularly true if the trend of the interest rate is downward, for then a short-term investment must soon be replaced at a lower yield. The investment expense is also reduced if it is not necessary to change investments too frequently. Hence, a large proportion of real-estate mortgages is found in the assets of life-insurance companies. Long-term bonds are also largely represented. For special reasons, investments in stocks are limited by law in some states to particular types of preferred or guaranteed stocks. In well-managed companies, loans on collateral are small and represent only temporary placements until suitable permanent investment can be made.

Companies in the second group are intermediate between these two in the way in which their probable loss requirements dictate their investment needs and policies. They cannot rely fully on current income to meet all exigencies of loss requirements. On the other hand, they do not need to hold such a proportion of highly liquid assets as companies of the first type.

The total assets as of Dec. 31, 1944, of fire and marine carriers admitted to do business in New York were $3,523,327,699. Their distribution by type is shown in the accompanying table.

ASSETS OF FIRE AND MARINE CARRIERS*

Type	Amount	Percentage
Real estate	$ 59,719,957	1.7
Mortgage loans	25,808,371	0.7
Bonds and stocks	2,912,063,405	82.7
Collateral loans	227,936	
Cash in office and bank	338,923,974	9.6
Premiums in course of collection	144,966,152	4.1
Miscellaneous	41,617,904	1.2

* Advance Printing of Principal Statistical Tables from *New York Insurance Report* 1945, p. 57.

For the casualty carriers the total assets were $2,724,186,846.

ASSETS OF CASUALTY CARRIERS*

Type	Amount	Percentage
Real estate	45,197,364	1.7
Mortgage loans	18,237,013	0.7
Bonds and stocks	2,211,848,718	81.2
Collateral loans	115,000	
Cash in office and bank	254,084,128	9.3
Interest and rents due and accrued	8,486,582	0.3
Premiums in course of collection	166,027,920	6.1
Other assets	20,190,121	0.7

* Advance Printing of Principal Statistical Tables from *New York Insurance Report*, 1945, p. 132.

ASSETS OF LIFE-INSURANCE CARRIERS

Type	Amount	Percentage
Real estate	854,682,202	2.4
Mortgage loans	5,344,139,334	15.0
Bonds and stocks	26,409,745,942	74.0
Policy loans and premium notes secured by policy reserves	1,759,218,301	5.0
Cash in office and bank	546,900,193	1.5
Interest and rent due and accrued	277,059,828	0.8
Deferred and uncollected premiums	468,196,931	1.3
All other	14,155,156	
Total*	35,674,097,887	

* Advance Printing of Principal Statistical Tables from *New York Insurance Report*, 1945, p. 29. The item of deferred and uncollected premiums is an offset item against part of the reserve and its entry is made necessary by the prescribed manner of computing the reserve. It is not an investment of the company. The volume of policy loans is determined by the action of policyholders in borrowing from the company rather than by the desire of the company for that form of investment.

Examination of these data shows that in all cases real-estate holdings are small. This is partly due to statutory restriction. The greater liquidity of the fire-and-marine and casualty-company investments, than those of the life companies, is immediately apparent. Were the stock and bond investments separately shown, as in stock or bonds, the difference in investment practice would be further apparent. Though the necessity for liquidity is not so great in a casualty company as in a fire-and-marine company, the investment policies of the former class has tended to follow those of the latter. The data do show a slight tendency toward more permanent investments in the increase in the proportion of mortgages with reduction in stocks and bonds.

In all three groups the figures are not quite representative of what has been normal practice in the past and may again become normal. They reflect the part of insurance carriers in financing the war effort. All types of carriers, indeed, almost all carriers of every type, have greatly increased their holdings of United States bonds. On this account all carriers are in considerably more liquid condition than usual, for the United States bonds they hold can readily be converted into cash should occasion require. The low yield of such bonds makes them unattractive in normal times. Without implying that patriotic motives had no part in this trend, it may be noted that the supply of other suitable investments in the market was restricted.

Investment Profits for Stockholders.—Because the dividends to stockholders of established insurance companies are large when expressed as a percentage of the capital, it is often argued that excessive profits are made in the business. This serves the reckless promoter in securing capital from those who do not carefully investigate his offerings. It also serves the agitator as apparent evidence that rates are excessive. Since the investors (it would perhaps be more accurate to call them "hopeful speculators") seldom realize the returns promised and since the companies show conclusively by abundant figures that in the same years in which dividends of 16 to 25 per cent on their capital have been paid, there have been no underwriting profits, it is appropriate to investigate the source of these dividends. It is to be found in the returns from investment of funds, or as they are called in the business, the "banking profits."

In few lines of insurance other than life insurance are the probabilities of loss predictable with sufficient precision to permit the making of rates within a margin of error of 2 or 3 per cent.[1] When the contracts are for short terms, say one year or less, and losses are fairly distributed over the year, something less than the total premium income is invested on the average about one-half a year.[2] At a conservative rate, the interest earned on such an investment is less than a reasonable assumption as to the margin of error in the premium rates. Hence, as indicated in Chap. XX, the interest factor is not consciously taken into account in rate making.[3] Indirectly, when the force of competition is considered, this influence may be felt. In calculating underwriting results, investment yield is not considered, but the comparison is made between premiums and

[1] There is reason to doubt whether the same statement would not apply to life insurance, were the contracts not for long terms during which accidental errors in individual years iron themselves out.

[2] The usual practice is to allow agents about 60 days for paying premiums on their policies. If commissions and agency expense approximate 25 per cent (it varies by lines of insurance), the company receives about 75 per cent of the premium on any policy 2 months after its issue. The head-office expense of getting the policy records in and the contribution to other expense during these 2 months will have consumed another 5 per cent. If the contemplated loss ratio is 50 per cent, there is about 2 per cent a month available and disbursed, for the remaining expenses and taxes. Losses, assuming a uniform spread over a year, will be about 4 per cent a month. Although losses begin as soon as the policy is issued, time must be allowed for adjustment. An assumption of 2 months is a little long, but it will serve for rough calculation. This will mean that loss payments begin about the time the company receives the money and continue at a fairly uniform rate until about 2 months after the policy expires. Contribution to expenses, of course, ceases on its expiration. From these considerations, it will be seen that the company has an initial fund of 70 per cent, all of which, except for operating cash, it may invest, the amount attributable to any one policy, and so invested, diminishing fairly uniformly over a year. Assuming earnings of 5 per cent, this would yield not to exceed 3½ per cent of the premium charged, which confirms the above statement. The case has been much simplified by omitting from consideration policies for terms longer than 1 year, and other complicating factors, but this does not affect the results greatly.

[3] In the case of workmen's compensation insurance the interest earnings on amounts set aside for deferred payments on long-term indemnities is taken into account in preparing the statistical data for rate-making purposes.

losses and expenses. The net balance constitutes the underwriting gain or loss. The investment yield, though small in the case of the individual policy, is large in gross amount for a substantial company and may offset losses on underwriting, or go to the surplus account of the company and be available for dividends to stockholders. Thus, the total assets of New York joint stock fire-and-marine-insurance companies, as of Dec. 31, 1944, were $1,154,967,358; their capital, $134,046,195, and surplus, $531,344,450. Their income from interest, dividends, and rents during 1944 was $38,000,000, or about 3⅓ per cent of the total assets.[1] There was a small additional profit on maturity and sale of investments and appreciation in market values; and taking all factors into account, the average yield would be a little larger than the above. Assuming the entire interest, dividend, and rent earnings to be paid in dividends, this would provide an average dividend on the nominal capital of about 28 per cent. In fact, the dividends in 1944 of these companies were $27,000,000, about $11,000,000, less than the interest earnings without taking account of profits on turnover of investments.[2]

The foregoing discussion and illustrative figures bring out several significant facts. First, they show the important part investment income plays in the insurance business, a fact well appreciated by directors who are generally better qualified as investors than underwriters. Second, they show that dividends may be paid which are not at the expense of policyholders, except to the extent that the advance payment of premiums furnishes funds for investment. Third, they show that the capital invested in insurance may be adequately rewarded without underwriting profits, if the underwriting income is adequate to provide fully for losses and expense, including within the meaning of losses, not merely the losses of the current year but such losses modified by an apportionment over several years of excessive losses in bad years. Although the reasoning and

[1] If the investment return is to be accurately estimated, the rate should be calculated on the mean invested assets, but precise accuracy is not necessary to illustrate the point, and the detailed adjustments might cause confusion and misunderstanding.

[2] Advance Printing of Principal Statistical Tables from *New York Insurance Report*, 1945, pp. 48, 60, 72, 84.

illustrations have been based on fire-and-marine insurance, the principles apply broadly to all except life insurance, in the premiums for which the interest rate is allowed for.[1]

Although these considerations have brought out important facts, there is likelihood of misinterpretation if care is not exercised. It was pointed out that the investment earnings of the New York companies furnished the means for a dividend of about 28 per cent on the *nominal* capital invested. This must be carefully distinguished from the real capital, for, if the surplus is considered to be part of the capital invested, the available return is less than 8 per cent. While this is much smaller, it yet does not present an entirely correct picture of the prospect of return to one investing in the stock of a new insurance enterprise. It has already been stated that to get a start the stock must be paid for at a figure above par. Let it be assumed it is paid for at 200 per cent. At the end of the first year some of the paid-in surplus will be absorbed in establishing the business. The statement may show a further impairment of the original surplus at the end of the second year. It will probably not be restored before the end of the fourth. The exact progress will depend on circumstances, *e.g.*, whether the carrier is associated with an established company and is receiving its support; and on the development policies pursued, *i.e.*, whether the carrier rapidly expanded or grew slowly. Since it will be unwise and illegal to pay dividends until a condition is reached where the paid-in surplus will still remain intact after payment of the dividend, it is safe to say that a period not much, if any, less than 5 years must elapse before dividend payment may be begun. Assuming that the investor estimates a fair return on his money to be 5 per cent, this deferment of return adds approximately 30 per cent to his investment and his actual investment is 260 per cent of its nom-

[1] It should not be inferred from the above that no underwriting profits are made. These, however, are quite variable and sometimes there is an underwriting loss. It is also difficult to estimate what is the real underwriting profit or loss since the full unearned-premium reserve is not required under normal conditions for the future loss and expense payments on existing policies. The point to be noted is the importance of the investment income as a source of profit to stockholders in the case of stock companies and of dividends or reduction of expense charges to policyholders of mutual companies. In 1944 there were substantial profits from underwriting.

inal par value. But this takes no account of the risk run on his capital during the early period, when that risk was greatest. In view of these considerations he would, indeed, be bold who would assert that capital invested in insurance enterprises yields inordinate return. So far as known to the writer, no complete study of actual results, which has taken into account the losses incurred by the investors in unsuccessful insurance enterprises, has been made.

The conclusion just reached is consonant with the one that is indicated by independent reasoning, since excessive returns would invite new capital into the business, which if not called for by expanding needs would reduce the average return by increasing expense in competition, or by unwise rate competition increase the loss ratio, tending to create underwriting deficits to offset investment gains.

This discussion of insurance stocks as an investment is somewhat of an excursus from the primary topic under consideration, but is proper at this point in view of the recognized fact that it is primarily the investment side of the business to which the management of most insurance enterprises looks for the profits for stockholders.

Trustee Character of the Insurance Business.—Although the assets of insurance carriers are not trust funds in the sense that they are deposits received under specific trust agreements prescribing how they are to be used, as with trust companies, they are trust funds in the sense that, while the legal title rests with the carriers, it has continuing obligations in connection with their use. This trust character imposes certain limitations and the performance of specific duties, on the carrier.

The insurance carrier must confine its activities to the insurance business. It would not be fair to its policyholders for it to engage in mining enterprises, in trading, or in transportation, no matter how profitable such activities might be to the proprietors of the company. But a company may have to dispose of goods acquired as salvage, and so from time to time engage in a sort of merchandizing; or a surety company may have to engage in extensive engineering operations to complete a contract if it may in that way reduce its losses.

The carrier must treat all classes of policyholders fairly and

equitably and is not free to furnish insurance gratis to favored persons as a merchant might give away goods or sell them at reduced prices to friends. It must see that its premiums are collected, or its policies canceled. Only in rare cases is it under the obligation of a common carrier to serve all who seek insurance and are willing to pay the price.[1] But the insurance company often finds itself in the class with the common carrier in that its rates are subject to supervision or specification by state authorities.

The carrier's income and disbursements must be rigidly accounted for and its accounts kept open to the inspection of proper authorities. Periodic summary statements and balance sheets must be published in prescribed form for the information of its policyholders and of the general public.

In the published balance sheet, assets must be valued fairly, and the liabilities must be fully stated. This obligation is clear, but its enforcement is not always easy. It has been a favorite device of the management of an insurance company that is not too scrupulous in observing its obligations to inflate the value of assets whose actual value is not easy of determination.

Reserves.—Liabilities for future obligations are usually designated as "reserves." As has been pointed out, this term does not connote cash or securities set apart for the special purpose. The reserve is purely a balance-sheet figure representing the amount chargeable against the total assets to cover the particular liability so designated. This topic will be more fully discussed in the following chapter.

Surplus—Its Ownership and Disposal.—The surplus of an insurance company is the balancing figure of its balance sheet. It is the excess of assets over the sum of the liabilities and the capital, if there is any. The ownership of the surplus depends on the type of company and on the contracts between it and its policyholders. In a mutual company it is the property of the body of policyholders, although sometimes mutual life-insurance companies have policies in force which provide that the policyholder shall not share in the surplus of the company. Formerly

[1] Carriers of workmen's compensation insurance in Arizona, or of automobile-liability insurance in Massachusetts, must insure all applicants. There are minor exceptions in Massachusetts.

mutual companies offered these so-called "nonparticipating" policies direct to the public. The laws of certain states having forbidden this, it is not often done, but policies that have lapsed and are being carried as extended-term insurance are often nonparticipating. Annuities are usually written under a nonparticipating contract. In whomever the ownership of the surplus rests, the control of its disposition rests with the board of directors as managers of the company, subject to its policy contracts.

The present practice of mutual companies is to distribute annually to policyholders such part of the surplus as may be deemed proper, having regard to security of the company and equity among classes of policyholders. The methods of making the apportionment differ so greatly, according to the kind of business, and in some cases involve such detail that no complete discussion is possible here. It is the usual practice to time the distribution to coincide with the next premium-due date, which facilitates payment by deduction from the premium due, and also develops the maximum competitive advantage of the mutual.

The policy contracts of mutual carriers usually make the methods of surplus distribution adopted by the board binding on the policyholder. About 1900 when the dividend periods of many life-insurance policies ended, and dividends were much smaller than the estimates made when the policies were sold, several disgruntled policyholders brought suit for accounting, but the courts did not sustain them. More recently a policyholder of a large mutual casualty-insurance company brought suit for his prorata share of the surplus earned during his membership but did not succeed. The court held that the amount of surplus required from time to time was a business question to be decided by the directors in which, in the absence of bad faith, the court would not interfere.[1]

As a part of their duty of considering the treatment of policyholders, the state insurance commissioners give attention to the dividend practices of mutual carriers, particularly of mutual life-insurance companies. Reports of examination of such companies frequently contain detailed and critical discussions of dividend

[1] *White Fuel Corporation v. Liberty Mutual Ins. Co.*, 313 Mass. 165; 46 N.E. (2n) 548 (1943).

formulas. The point of investigation is whether or not there is any unfair discrimination among classes of policyholders.

Sometimes joint-stock companies give their policyholders by contract provision a right to share in the distribution of the company's surplus. In that case, questions may arise as to the respective rights of stockholders and policyholders. Usually, however, the interest of the individual policyholder is not so large as to lead him to take the case to court.

Where the surplus is the exclusive property of the stockholders, the considerations that determine the time and manner of its distribution are the same as with other joint-stock corporations, save for the necessity of a suitable fund to protect against catastrophe.

Valuation of Assets.—One index, as commonly believed, of success and good management in a business enterprise is the regularity of its dividends and the reasonable steady growth of its surplus. This is also one of the canons for testing an insurance company. Hence, it is the desire and effort of the companies' managers to meet this standard. An important factor in this effort is the valuation of the company's assets.

Real Estate.—An insurance company needs only the real estate required for office accommodation, and the intent of the law in most states is to restrict its holdings to this limit. But any company may find it necessary from time to time to take over real estate by foreclosure of mortgages, or in liquidation of debts arising out of its business. The total real-estate holdings should form a small proportion of the total assets, and no great fluctuation in the surplus will occur if these items are carried at the market value as determined by a fair appraisal, as is usually done. Occasionally, a mismanaged company tries to keep up an appearance of solvency by writing up the book value of its home office or other real estate, obtaining false appraisals to support it. Sooner or later, however, the authorities detect such a practice and deal appropriately with company and management.

Mortgage Loans and Collateral Loans.—If properly secured, loans are always carried at the amount lent. If the security is not up to legal standard, the value is reduced by exclusion of all or a part of the ill-secured loan from the "admitted assets" as certified by the state authorities.

Stocks.—Stocks have a fluctuating market value. They may be carried on the books at par, at cost, or at some figure that represents their current market value. For current-statement purposes it is generally agreed they should not be entered above the current market value. But variation in market value may cause serious fluctuations in the surplus. This may be avoided by setting up in good years a reserve (liability item) for security fluctuations, which may be reduced in adverse years. Such action is tantamount to carrying the investment at something less than its real market value, but is usually preferred as more frankly showing the company's condition and policy.

Bonds.—Bonds are less subject to fluctuations in market price than are stocks. They are evidences of debt of the issuing corporation rather than of proprietary interest in it. Unless there is some question as to security or their exemption from taxation which makes their actual yield more than the nominal, their price will depend upon the relation of their nominal interest rate to the current effective rate. Not only does fluctuation in value of bond holdings affect the showing of surplus at a particular time, but it also varies the interest earnings over a period, because to the actual interest received must be added the increase in value during the period, or the decrease deducted, as the case may be. This is undesirable and tends to present a false record of results. Particularly in the case of life-insurance companies and others that expect to hold their bonds to maturity, it is, therefore, often better to value the bond holdings by *amortization*, so that the yield of any block of bonds will stay uniformly at the figure which they were bought to yield, the premium or discount being gradually absorbed as they mature.[1]

Other Assets.—The other assets will be cash, or open accounts, premiums in course of collection, and minor items. These are commonly valued at par, though suitable deductions should be made for uncollectible items.

SUMMARY

1. Since premiums are collected in advance and losses are payable, on the average, rather later than the middle of the policy

[1] See MACLEAN, J. B., "Life Insurance," Chap. XII.

term, the insurance carrier always has a considerable amount of funds on hand suitable for investment.

2. These funds, though legally the property of the carrier, are not all earned but have some of the characteristics of trust funds.

3. The capital, and much of the surplus, of the carriers are not required in the business as in manufacturing and trading companies but are emergency guarantee funds.

4. In the interest of both the carrier and the public, such funds should be put to work. Investment of funds is therefore an important part of the work of the insurance carriers.

5. Owing to this aspect of the business, the carriers, particularly life-insurance companies, serve a public purpose as collectors of small sums which are accumulated into suitable volume for investment. While this is an important service, it is subsidiary and should not be so emphasized as to obscure the main insurance service.

6. The types of investments best suited to the several classes of insurance companies depend upon the probable need of quick realization in cash which may arise from the type of business done.

7. The investment earnings of well-established companies furnish an adequate return to stockholders, without the necessity, in many cases, of underwriting profit.

8. The nominal dividends on insurance stock indicate return to investors in excess of the actual and lead to false conclusions as to value of such stocks, and as to treatment of policyholders.

9. The trustee character of the insurance business implies certain obligations and limitations on insurance companies, most important of which are

a. Confinement of activities to the insurance business.
b. Equitable treatment of all policyholders.
c. Accuracy of accounting, and publicity of accounts and balance sheets.
d. Setting up suitable reserves to cover deferred liabilities.

10. The reserve is not a fund set apart, but a bookkeeping item in the balance sheet expressive of a charge against assets.

11. The surplus may belong to policyholders or stockholders or both; its distribution under the terms of policy contracts is a special problem for the management of the company.

12. Assets are usually valued at their market price, but it is often desirable to value bonds on the amortization basis both to prevent erratic fluctuation in surplus and to show regularity of interest income.

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CHAPTER XXIV

RESERVES

The fundamental mutuality of insurance[1] gives the business the trustee character emphasized in the preceding chapter. The insurer's obligations under its contracts are, at the time of issuing the policy, all in the future, though the premiums are generally payable in advance. If a company were permitted to continue operations as long as it had no *matured* obligations that it could not meet (the ordinary commercial standard of solvency), it would in many, if not most, cases be perpetrating a fraud upon its patrons by using funds, paid to secure future service, to meet already incurred obligations to others. The only way in which the business can be fairly conducted on an advance-premium basis is by making suitable provision in advance for obligations contracted to be met in the future, *i.e.*, by setting up their present values as liabilities.

Reserves as Liabilities.—The use of the term *reserve* to designate such present values creates a certain difficulty at the outset because the commonly accepted concept of a reserve is a fund or stock of resources, not otherwise required, voluntarily set aside for a particular purpose or to meet future contingencies. It is a common practice in other businesses to earmark a portion of surplus or of profits and to speak of that portion as a reserve. This leads to a more or less common notion that reserves are really surplus which the proprietors of the enterprise have chosen to dedicate to another purpose, the dedication being a voluntary act which may be reversed. There are some reserves set up by insurance companies that are of that nature, but they are the relatively smaller and less important ones.

It would be interesting academically to trace the origin of the custom of designing the liabilities of insurance companies as reserves, but it would probably add little of practical value to this

[1] See pp. 272–273.

discussion. The usage is of long standing. It will be sufficient if it is realized that such reserves are true liabilities and, under the operation of the law of large numbers, only to a limited extent preparation for unforeseen contingencies. It is true that the amount of reserve necessary for certain purposes is often not susceptible of precise calculation except in the probability sense. But this is a matter of detail which does not change the character of the item. The amount of the liability may have to be estimated. The existence of the liability is the important fact.

Types of Reserves.—For convenience of discussion, reserves may be classified as statutory and voluntary, depending on whether or not they are required by statute.

The reserves that fall in the first class are the present values of matured and pending claims and expenses, unearned-premium reserves, and similar obligations. The need of providing for these is in general so clear that no one could object to the requirement. Indeed, the requirement should not be necessary, but the frailty of human nature has demonstrated more than once that it is.

Voluntary reserves are set up by prudent and well-managed companies to cover unforeseen contingencies. Only approximate predictions of probable future events can be made in reliance upon the law of large numbers and the assumption of uniformity of conditions. Therefore, unless provision is made in advance, occasional adverse fluctuations may be very embarrassing. It is prudent to reserve at least part of the gain from favorable variations to meet the loss from the unfavorable.

The reserves held by insurance companies may again be classified into two groups: those for payment of matured obligations and those for the payment of obligations to mature in the future. In the first class are (1) claim reserves, (2) claim-expense reserves, (3) other expense reserves, (4) reserves for taxes, and (5) reserves for dividends voted. In the second class fall (1) the legal reserve for life insurance, (2) the similar reserve for noncancelable disability insurance, whether included as a disability provision in life policies or written in a separate contract, (3) the unearned-premium reserves of fire, marine, and casualty companies, and (4) the various contingency reserves.

Claim Reserves.—There are two sorts of *claim reserves* necessary to a true exhibition of a company's financial condition:

(1) that for payments in the future for claims already presented whether or not determined and recognized as valid, and (2) that for claims to be presented in the future because of occurrences that have taken place before the statement date. In some cases, as in workmen's compensation and liability insurance, the two are merged.

Under any insurance policy it is necessary for the claimant to prove his right to the payment promised, so that in any company doing an extensive business some claims are necessarily in process of adjustment on any particular date. Others may have been disputed, but the time within which suit may be brought may not have expired. Still others may be in litigation. Such claims account for part of the reserve item in all cases and in some for all of it. In addition, the provisions of some contracts, such as personal-accident and workmen's compensation policies, provide that claims are to be paid in installments over a more or less extended period of time. Under other contracts, such as life-insurance policies, the insured or the beneficiary has the right to ask that payments be so made. The present value of these payments must also be set up as a liability.

In the case of life-insurance policies payable in installments, either for a fixed period or as a life annuity to the beneficiary, it is usual to enter the claim at the amount of its present value at the time it is presented. The original contract is then regarded as matured, and it is taken up and a new *supplementary* contract issued to the beneficiary under which the company agrees to pay the installments provided by the original contract.[1] When this is done, the present value of the new contract is entered as a disbursement under claims paid and again entered as income under "consideration for supplementary contracts" either "involving life contingencies" or "not involving life contingencies." The subsequent installment payments made are then reported under disbursements as payments on account of supplementary contracts. The present values of the future payments are liabilities and are reported as *reserves* for supplementary contracts, sepa-

[1] The present value of this contract is, of course, less than the sum of the installment payments because interest will be earned on the balance remaining with the company. This present value is always equal to the amount of single-sum benefit bought by the premiums on the original contract.

rated between those involving life contingencies[1] and those not involving life contingencies. Thus, the total claim reserve of a life-insurance company is broken into several parts on the liability side of the balance sheet, but the titles of the items make their meaning fairly clear.

The second part of the loss reserve (that for incurred but unreported losses) can only be estimated but, if the event giving rise to liability has occurred, the required payment is properly a charge against the revenues of the period during which it has occurred and not against future revenues. Although the requirement of this provision for the unknown may seem a hardship, in these days of rapid communication the item is relatively small and the past experience of the company furnishes the basis for a satisfactory estimate.

Claim Expense.—The claim-expense item includes provision for expenses already incurred but not fully paid, as well as for claim expenses to be incurred in the future on account of past occurrences. The nature and extent of this item vary greatly according to the kind of insurance. For example, in life insurance it is negligible. In fire insurance it will rarely be great since ordinarily the cost of adjusting claims involves only that of investigating the conditions at the time of the fire and the extent of the loss and damage. On the other hand, the settlement of surety losses is often a matter of considerable time and even litigation. Workmen's compensation losses require continuous attention to see that the medical and surgical care is the best adapted to a maximum and early recovery and to prevent malingering. The terms of the liability policy call for the defense of suits against the insured which necessarily means large expense and considerable deferment of its final liquidation.

In liability insurance, the loss expense is so inextricably interwoven with the true loss that no attempt is usually made to separate them, and they are treated throughout as one and the same. That is not true to the same extent of workmen's compensation, but for reserve purposes the expenses are treated in like manner.

[1] Since these are annuities, it is now the rule for preparing the annual statement to include the reserve for these with the reserve for annuities.

Reserve for Other Expenses.—If, as is the practice in casualty insurance, premiums in process of collection are treated as an asset, the commissions to agents, which will be deducted when such premiums are paid, must be regarded as a liability. If the practice is, as in fire insurance, to consider as assets only the agents' net balances, such a reserve is not needed. In either case there may be additional contingent commissions if the agents' remuneration is based partly on the experience with their business. Other unpaid expenses incurred will be for rent, salaries, supplies, and miscellaneous minor services. In the statements they are sometimes segregated although the total is usually small.

Reserve for Taxes.—In general, state taxes are imposed as a percentage of premiums received during a calendar year but are not payable until after its close. At any given statement date, therefore, taxes will have accrued, and if provision is not made to meet them when they become due a burden will be passed along to the future. The same principles apply to real-estate taxes and to other taxes such as the federal income taxes. The reserve for taxes might be lumped with that for expenses, but in that case it would not be possible to work out correct ratios of incurred expense. It is also desirable to segregate premium taxes, at least, since they are not true expenses over which the management has control but indirect taxes on policyholders which the management is required to collect and which it should pass on through adjustment of rates if possible. Separate reserves for taxes at statement dates also permit a more accurate working out of tax rates for this purpose.

Reserves for Dividends.—If dividends to either policyholders or stockholders have been voted, the funds required for them are not available for other purposes. They are carried as liability items.

In the latter part of the nineteenth century the large life-insurance companies issued most of their participating policies on a deferred-dividend basis, the most common period being 20 years, *i.e.*, no dividend was payable on any policy unless the insured survived the period of deferment and had maintained his policy in force for the entire period.[1] The surplus earned under these

[1] See MACLEAN, J. B., "Life Insurance," pp. 171–173.

policies was generally regarded as free surplus for which there was only general accountability. The surplus funds so developed were huge, and gross extravagance and other abuses resulted. Consequently, after a legislative investigation in 1905 had disclosed these abuses, the law of New York, where the largest companies were domiciled, was amended to require provisional apportionment and the carrying of the fund as a liability. Deferred-dividend policies have not been popular in recent years, but some of the life-insurance companies have a small amount of that business still outstanding and carry a reserve liability for the accumulated dividend fund.

Unearned-premium Reserve of Fire and Casualty Companies. The unearned-premium reserve represents the portion of the gross premiums on policies in force corresponding to their unexpired period. There are two reasons why such a reserve should be carried: (1) because the company is obligated to cover the risk for the remainder of the period, and (2) because in most such policies the company and the insured retain the right of cancellation, and on cancellation the unearned premium must be refunded. When the first reason is uppermost in mind, this reserve is sometimes called the "reinsurance" reserve, since presumably another company could be found to reinsure the risks for this amount. This reserve is the largest item on the liability side of fire carrier statements. It constitutes about 65 per cent of the total liabilities of such companies and about 25 per cent of the total liabilities of casualty carriers.

Reserve in Life and Disability Insurance.—Life-insurance policies are issued to cover against an increasing risk but at a uniform or "level" premium, the excess premiums in the early years with their interest earnings constituting an accumulating fund contributory to the payment of a claim when it matures. This investment element constantly diminishes the net amount which the company has at risk.[1] The same thing is true of non cancelable accident and health (disability) policies. From certain points of view the reserve on these policies might be looked upon as an unearned-premium reserve, but one gets a clearer idea of its nature if it is considered from a slightly different point of view. The ordinary whole-life policy may be taken as an example.

[1] See Chap. X.

The contract may be thought of as an exchange of two promises, each of which may be separately evaluated not only at its inception, when they are or should be of equal value, but at any future date. The company promises that, if the insured keeps up his premium payments, it will pay the face amount of the policy on his death. The insured promises to pay a fixed premium at each anniversary of the policy during his lifetime. The present value of the company's promise is a liability which can be calculated by the use of suitable assumptions as to future mortality and interest. The present value of the future premiums constitutes an offsetting asset which also may be valued on the same assumptions. With increase in the age of the insured the value of the liability increases and the value of the asset decreases. In other countries the two items are frequently shown separately on the respective sides of the balance sheet. Since, except at the inception of the policy, the value of the liability exceeds that of the corresponding asset, it is the practice in this country to set up only a single item on the liability side equal to the excess of the liability over the asset.

Since the loading for expenses[1] in the future premiums will be required to meet future expenses, it is customary (and mandatory by law) to value only the *net* premium, *i.e.*, the provision for claim payment. The lapse rate is not considered in determining the values under life-insurance policies because they provide for benefits based upon the reserve to the life policyholder in event of lapse. In the case of disability policies under which no surrender values are allowed, the lapse rate may also be considered.

The determination of the reserve in this way is known as a determination by the *prospective* method, since the point of view is one looking to the future, comparing the value of the company's obligations with the policy assets available to help meet them. If the reserve is determined as an accumulation of unearned premiums, the method is known as a *retrospective* method, since it is based on a review of the past. So long as the same bases of mortality and interest are used as were used in fixing the net premium (the usual conditions met in practice), the result is the same whichever view is taken. However, since actual experience

[1] See p. 374.

rarely conforms exactly to the assumptions as to mortality and interest made in fixing premiums, it seems that the concept underlying the prospective method is the more logical one to use in trying to understand the nature of these reserves.

In Chap. X an example was given of the accumulation of the life-insurance reserve retrospectively looking upon it as a savings fund.[1] The same contract may be used to illustrate the prospective approach to the determination of the reserve. The policy considered was an ordinary-life contract issued at age forty-five whose net annual premium according to the American Experience Table on a 3 per cent interest assumption was $29.67 per $1,000 of insurance. At the end of 5 years the insured will be fifty. At this age, according to the same mortality and interest bases it will require a single sum of $555.22 to provide $1,000 payable at death. This is the company's *gross* liability which, in some countries, would appear on the liability side of the balance sheet.[2] To offset this in part, the company will have the present value of $29.67 per year for the remainder of the lifetime of the insured. According to the same mortality table and interest rate $1 per year, payable in advance each year a person now aged fifty lives, has a present value of $15.2710. Hence, the present value of $29.67 per year is $29.67 × 15.2710 = $453.09. This might appear on the asset side of the balance sheet. In this country, as previously explained, the two items are merged and the net difference appears on the liability side, giving a reserve of $555.22 − $453.09 = $102.13.[3]

Voluntary and Contingency Reserves.—Voluntary and contingency reserves also fall into two categories: (1) those associated with the valuation of assets, and (2) those set up for unforeseen contingencies. Examples of the first class are reserves for depreciation of real estate owned, or for depreciation of the real estate mortgaged to the company as security for a loan, or for uncollectable balances due from agents.

[1] See pp. 164–167.

[2] The balance-sheet figure will be the sum of such values for all policies in force, individual items not appearing.

[3] On p. 165 this was given as $102.20. The true net premium is not $29.67 but $29.665, and if this had been used the present value of future premiums would have been $453.02, yielding $102.20 as the reserve.

Reserves of the first category may appear on the liability side of a balance sheet along with other reserves. Not infrequently, however, they appear as deductions on the asset side. In the form of annual statement approved by the National Association of Insurance Commissioners there is a separate section on the asset side of the balance sheet headed Deduct Assets Not Admitted. Reserves in this form are usually grouped under this head along with other deductions for various assets that do not conform to legal standards.

Reserves set up for unforeseen contingencies always appear on the liability side and are variously designated. Sometimes a single item is entered for the aggregate of such reserves. Sometimes several separate items are entered, such as "Reserve for Catastrophes," "Reserve for Mortality Fluctuation," or "Reserve for Investment Fluctuation."

Methods of Calculating Reserves.—Reflection on the foregoing section will indicate that, except for the voluntary and contingency reserves, the determination of the required amount of any reserve is a matter of direct or indirect inventory. That is, a list of the items in respect to which reserves are needed must be prepared, appropriate values must be found for each item, and the total summed. In principle the problem is not different from that of taking an inventory of stock on hand in a mercantile establishment. In practice there is considerable difference, since the work must be done from book entries and files or card records rather than by counting and valuing physical goods. The methods of fixing the reserve differ according to the kind of reserve and the type of records kept by the companies. In the following paragraphs the more common methods are briefly outlined.

Loss Reserves.—All carriers keep some form of loss register or claim register in which claims are entered serially as they are received with various particulars adapted to the individual carrier's methods. Almost always the register shows the final disposition of the case. The register is supplemented by individual claim files and sometimes by card records. From this source the list of unsettled claims is obtained.

In life insurance, where the face of all policies is payable at death and where the claim procedure is so simple that relatively

few cases remain unsettled for any appreciable time, the list may be taken from the register and totaled. That part of the reserve representing the present value of amounts due in the future on supplementary contracts, whether involving life contingencies or not, is a rather simple matter of calculation in the actuarial department on the basis of standard interest and mortality tables.

For example, the insured may have elected to have a \$10,000 policy payable to the beneficiary in equal installments of \$680 payable annually for 20 years certain. When the claim came in and the first payment of \$680 was made, the company would enter as claims paid (disbursement) \$10,000 and as consideration for supplementary contracts not involving life contingencies (income) the difference between the face and the installment paid, \$9,320. It would set up as a liability (reserve) the same amount. This would be credited annually with interest on the remaining balance at the rate assumed (3½ per cent)[1] and diminished by the payments. After three payments had been made, the reserves would have decreased to \$8,902, the present value at 3½ per cent of the 17 remaining installments of \$680 each. If the installments were to be for the lifetime of the beneficiary rather than a term certain, the same principle would be followed except that a mortality table would be used to measure the contingencies. If the installments were \$600, the beneficiary were sixty years of age at the time a statement was to be made, and the American Experience Table of Mortality and 3½ per cent interest were used as the basis, the reserve would then be \$600 × 11.0324 (the value of a life annuity of \$1 at that age according to such table and 3½ per cent interest), or \$6,619.44.

In fire insurance, the situation is slightly more difficult since the amount of loss for which the company is liable must be ascertained by investigation and negotiation. This process takes time so that more claims will be open at any given date than in a corresponding volume of life insurance. The individual value of each must be determined for the reserve inventory. Sometimes preliminary estimates are entered on the claim register and changed as additional information is obtained. Even when these entries are not made, the estimates appear on the claim files.

[1] This was until recently the rate commonly used. Most companies now use a lower rate.

Such estimates represent the best judgment of the claim men in the light of all the facts known to them at the time they are made. It is customary to revise the estimate on each claim jacket as new information is received and, in some companies, to review periodically all open files and fix new estimates.

This method of *individual estimates* is theoretically available for any line of insurance. Its greatest weakness is the tendency to overoptimism on the part of claim estimators. Sometimes, when a company's finances have been at a low ebb and the statement is likely to show little if any surplus, the "wish is father to the thought" and reserves are consciously or unconsciously underestimated. Such conditions have led to the prescription by statute of methods of calculation, particularly for liability and workmen's compensation claim reserves.

Where the number of claims outstanding at a given time is small and there is considerable variation in the amounts of the individual claims, the individual-estimate method appears to be the most economical if not the only available one. It is almost exclusively used in fire and marine and allied lines of insurance, and in such casualty lines as surety, plate-glass, burglary, machinery, miscellaneous property-damage, and automobile-liability insurance.

As a check against overoptimism, the casualty statement blanks prescribed by the insurance commissioners contain schedules in which estimates at the end of prior years are compared with the subsequent payments and with revised estimates on claims still open. If these schedules show persistent underestimation of requirements, there is a presumption that the reserves in the present statements are inadequate and the commissioners act accordingly, usually making an examination of the company and determining by their own representatives what are proper reserves. If the company is still solvent on the higher reserve basis, the correction usually results in better estimates in the future.

Where the number of open claims is large, the individual-estimate method is burdensome and short cuts are sought. One such short cut, readily available when there is not too great variation in the size of individual claims, is the use of *average values.* The company's experience over a past period is exam-

ined, and the amounts of claims of particular types are tabulated and averaged. The averages so derived are then multiplied by the number of claims of these types outstanding at a statement date, and the product, less amounts already paid, taken as the reserve. The experience period used to determine the average values should be broken into several subperiods, and averages worked out for each in order to determine whether there is any tendency toward increase or decrease in the average size of claims. If so, the trend must be observed and probably (especially if the tendency is to increase) be projected in order to get an adequate average. This method is particularly suitable for the calculation of reserves for automobile-collision damage or for property-damage-liability insurance.

A variant of this method is the *notice-average* method. The average cost per notice of accident is multiplied by the number of notices received during the past year. From this total the amount already paid in respect of any such notices is deducted, and the balance is the reserve.

For valuing such benefits as life pensions granted to the permanently disabled under some compensation laws or widows' pensions, which involve both life contingencies and contingencies of remarriage, use is made of mortality and remarriage tables which indicate the probabilities of survival and of remarriage. This is the *tabular-value* method.

In the early history of liability insurance, reserves were set up by the individual-estimate method. The estimators of some companies proved too optimistic, producing inadequate reserves. This led to statutory enactments prescribing other methods. The average-value method, the first tried, also proved unsatisfactory, and new statutes prescribed a *formula* or *loss-ratio* method. This method uses average values for suits being defended under policies written three or more years prior to the statement date, the values to be used beginning at $850 for suits under the most recent of such policies and increasing to $1,500 per suit outstanding under policies written 10 years or more prior. The formula is used to calculate reserves for losses arising under policies issued during the three calendar years preceding the statement date. The reserve is the remainder after deducting from 60 per cent of the premium earned on such policies

the amounts actually paid for losses and loss expense. If the value of known outstanding claims determined by individual estimates exceeds this amount, the latter shall be the reserve.

Let it be assumed that a casualty-insurance company has written \$100,000 of liability-insurance premiums during each of the three calendar years, 1942, 1943, and 1944 and that the business was evenly distributed over the year. Then all of the premiums on the 1942 and 1943 business will have been earned but only one-half of those on the 1944 business. There will be an unearned premium reserve on the liability business at Dec. 31, 1944, of \$50,000. The earned premiums of the last three calendar years will then be as shown in column (2) of the following table. Let it be assumed that there have been paid for losses arising under the several sets of policies the amounts appearing in column (4) and for loss expense the amounts appearing in column (5). Then the computation of the loss reserve in respect of this business as of Dec. 31, 1944, will be as shown in the accompanying table.

EXHIBIT OF FORMULA LOSS-RESERVE COMPUTATION

Year of issue	Earned premiums	60% of earned premiums	Paid for		Total payments (4) + (5)	Balance (3) − (6)	Individual estimate of open cases
			Losses	Loss expense			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1942	\$100,000	\$ 60,000	\$40,000	\$ 8,000	\$48,000	\$12,000	\$10,000
1943	100,000	60,000	25,000	5,000	30,000	30,000	28,000
1944	50,000	30,000	5,000	1,000	6,000	24,000	20,000
Total....	\$250,000	\$150,000	\$70,000	\$14,000	\$84,000	\$66,000	\$58,000

In this case the reserve would be the sum of the items in column (7), or \$66,000. If, however, the entry on any line in column (8) based on a review of the individual cases were larger than that in column (7), it should be substituted for the entry in column (7). If the entries in column (8) were \$14,000, \$28,000, and \$20,000, the \$14,000 entry in column (8) would be

taken instead of the $12,000 entry in column (7) and the reserve would be

On business of 1942	$14,000
On business of 1943	30,000
On business of 1944	24,000
Total	$68,000

To this would be added the value on the basis of the average values given of suits outstanding from earlier business, in order to arrive at the total reserve. If the company's claim men feel that the average value per suit is less than the open suits could be settled for, then voluntary addition ought to be made to bring the total to the amount they estimate will be required.

This method rests on the assumptions that (1) the rates charged are on the average correct; (2) 60 cents of each premium dollar will be required for losses and loss expense; (3) if 60 cents has not yet been expended, it will be required either to meet the subsequent payments on known claims or for claims to be presented in the future because of past occurrences; (4) after 2 years from the expiration of the policy, if the company has not yet been called upon to defend its insured in court, the probability of being required to do so is so small as to be negligible; and (5) though these considerations apply generally, there may be individual companies which, by reason of poor underwriting, poor claim administration, or other conditions, need higher reserves.

The formula method is also prescribed for workmen's compensation loss reserves, the percentage of earned premiums to be used being, in most states, 65. The average value per suit is not applicable to workmen's compensation losses since practically all cases are settled without resort to the courts. The reserve for open cases under policies issued more than 3 years prior is the total of their present values as determined by actuarial calculation. The status of a workmen's compensation case 2 years or more after the accident is usually sufficiently certain to permit accurate valuation. As in the case of liability insurance, if the total of the estimated cost of individual cases is in excess of the reserve produced by the fromula, the former must be used.

Where the claim reserve is not calculated by formula as in liability and workmen's compensation insurance, the reserve for

unreported cases is made up by examining past experience and finding the average ratio of delayed claims to claims outstanding at the statement date. This ratio is then applied to the computed reserve to arrive at the reserve for unreported cases.

This variation in methods is a practical necessity. The objective is always the same, *i.e.*, to arrive at a figure that fairly represents what the company may reasonably expect to be called upon to pay in the future for losses that have arisen prior to the statement date.

Claim-expense Reserve.—The claim-expense reserve is included in the claim reserve for liability and workmen's compensation cases. For other lines of insurance, it is usually found by determining from accounting records the ratio of the amount paid for claim expense to that paid for claims, and by applying this ratio to the claim reserve.

Unearned-premium Reserve in Fire and Casualty Insurance.—The unearned-premium reserve is determined by tabulating the premiums on the business in force, according to year or month of issue and term. It is customary to assume that the business issued in any period was uniformly distributed over that period, which is equivalent to its being concentrated at its mid-point. Thus, annual policies issued during the calendar year at the end of which the reserve is computed are assumed to have been in force, on the average, one-half their term and to have one-half to run, so that 50 per cent of the premiums upon them is unearned. On 3-year policies of the same year, one-sixth is assumed to have been earned and five-sixths to remain unearned. Similarly for other years of issue and durations. The assumptions conform reasonably closely to fact. If the tabulation is by months, policies issued in July to run one year will, on the average, have earned $5\frac{1}{2}$ months' premiums ($^{11}/_{24}$ of the annual premium) by Dec. 31 and $^{13}/_{24}$ of the annual premiums will be unearned at that date. Similarly, also, for other periods of issue and durations.

The major problem in calculating this reserve is the tabulation of the premiums in force by issue period and by term to run. Formerly it was a common practice to keep running, self-correcting book accounts for this purpose, as is still done by some of the smaller companies. The larger companies do the work more

economically with punched cards and sorting and tabulating machines. In essence this reserve is also an inventory of a company's insurance portfolio.

Reserves in Life and Disability Insurance.—The methods used in calculating life and disability reserves differ among the companies mainly according to size, methods suitable to a small company being too cumbrous for a large one, and, conversely, short cuts that save enormous labor for a large company having little advantage when the volume of business is small. In all cases two assumptions are made: (1) that the business is uniformly distributed over the year so that mean values may be used at any statement date with respect to the policies issued in any preceding 12 months' period ending on the same day (Dec. 31, June 30, etc.), and (2) that all premiums are paid annually in advance when due. The first assumption is realized with close approximation in practice. The second is not. At any statement date there are some policies for which the current premium is past due, *i.e.*, the grace period[1] has not yet expired. Also the premiums on many policies are payable semiannually or quarterly, and at the statement date there may be a semiannual or one or more quarterly premium not yet due. These are called "deferred premiums." A precise computation taking account of the exact status of each policy would involve an impossible amount of labor. To offset the excess reserve set up by the assumption as to payment, an entry is made on the asset side of the statement of the net *due and deferred* premiums. "Net," in this case, means the net premium according to the mortality table and interest rate used in calculating the reserves, not the gross premium less collection expense. If the collection expense exceeds the difference between the gross premium and the tabular net, a separate liability item must be set up for this excess. This is not often necessary.

In most states the statutory basis for reserves on life-insurance policies on standard lives is the American Experience Table of mortality with an interest assumption of 3 or 3½ per cent. Other tables, which are more suitable, are prescribed for determining reserves on industrial and substandard policies and on annuities.

[1] See p. 181.

There were prepared and published in 1941 two new mortality tables, the C.S.O. (Commissioners' Standard Ordinary) and C.S.I. (Commissioners' Standard Industrial) tables, which are considered appropriate representations of current mortality upon which to base premiums and reserves for the various branches of the life-insurance business. In 1943 several states passed legislation adopting these tables, with interest rates of from 2½ to 3 per cent, as standards of reserves on new policies. Owing to wartime shortage of help and the extra work in arranging new rate books and sets of nonforfeiture values, use of the new bases was not made mandatory in respect to policies issued prior to Jan. 1, 1948. But it is permissible to use these bases on policies issued prior to that date. Formerly the companies were not allowed to hold higher reserves than those produced by using the American Experience Table with interest at 3 per cent.[1] Companies are adopting lower interest bases for reserve, because of the fall in the market rate, which makes it an appropriate time to change the mortality base from the antiquated American Experience Table.[2]

A description of the technical procedure followed in calculating reserves is beyond the scope of this book. It is sufficient to note that, as in the case of the unearned-premium reserve in fire and casualty insurance, a properly classified tabulation of the amount of insurance in force under all policies (rather than premiums as in that case) must be prepared, to which unit values computed from tables are applied. Records must be kept to facilitate this tabulation. Similarly, records must be available to permit a suitable listing of the net premiums due and deferred. Usually the latter figure is arrived at by tabulating the gross premiums and deducting the average loading. This procedure simplifies the work since the listing may be made from the card

[1] The lower the interest assumption with any given mortality table, the higher the reserve.

[2] The legislation providing for the new reserve standards was recommended by the National Association of Insurance Commissioners. They have not yet been adopted in some of the states in which large life-insurance companies are domiciled, notably New York. The legislation also provided new methods for determining nonforfeiture values. Complete discussion of this legislation would go beyond the scope of a general text on insurance. See MACLEAN, *op. cit.*, pp. 126, 145.

files to prepare premium notices. It is sufficiently accurate for all practical purposes.[1]

Expense and Contingency Reserves.—The various expense and tax reserves are similar to corresponding items in the balance sheets of other business concerns. No special technique is necessary to determine them. Nor is there such uniformity of procedure in fixing contingency reserves, whether for underwriting or investment contingencies, as to warrant describing any particular procedure as typical.

Relative Importance of Reserves.—The several types of reserves discussed in this chapter are not of equal importance, but taken together they constitute by far the major part of the liabilities against which the assets are held. In Chap. XXIII, tables were given of the types of assets held by the fire-and-marine, casualty-and-surety, and life-insurance carriers admitted to do business in New York as compiled by the Insurance Department of that state from their annual statements as of Dec. 31, 1944. The following tables from the same source show the major

AGGREGATE LIABILITIES OF FIRE AND MARINE CARRIERS*

Item	Amount	Percentage of total liabilities
Losses unpaid (reserves):		
Fire	$ 123,161,084	7
All other	202,544,251	12
Unearned-premium reserve:		
Fire	820,441,020	48
All Other	309,193,297	18
Contingency reserves	88,854,407	5
All other liabilities	181,235,704	10
Total liabilities	$1,725,429,763	100
Capital, guarantee funds, and deposits	368,263,373	21
Surplus	1,429,634,563	83
Assets to cover	$3,523,327,699	

* Advance Printing of the Principal Statistical Tables from the *New York Insurance Report*, 1945, p. 69.

[1] For discussion of the difference between "net level premium," "full preliminary term," and "modified preliminary term" methods of setting reserves, see Maclean, *op. cit.*, Chaps. VI, VII.

AGGREGATE LIABILITIES OF CASUALTY AND SURETY CARRIERS*

Item	Amount	Percentage of total liabilities
Reserve for liability losses	$ 337,889,394	18
Reserve for workmen's-compensation losses	492,034,022	26
Reserve for all other losses	159,502,314	8
Loss-expense reserve	31,929,879	2
Unearned-premium reserve, including additional for noncancelable accident and health	499,051,751	26
Contingency reserves	189,793,073	10
All other liabilities	195,699,421	10
Total liabilities	$1,905,899,854	100
Capital, guarantee Funds, and deposits	178,703,835	9
Surplus	639,583,157	34
Assets to cover	$2,724,186,846	

* Advance Printing of Principal Statistical Tables from the *New York Insurance Report*, 1945, p. 137.

AGGREGATE LIABILITIES OF LIFE-INSURANCE CARRIERS*

Item	Amount	Percentage of total liabilities
Net reserves on policies and annuities	$28,245,163,043	83
Reserve for accidental-death and disability benefits	1,111,974,539	3
Reserves for supplementary contracts not involving life contingencies	2,298,997,866	7
Reserves for policy claims outstanding	227,333,613	1
Reserve for dividends and other policyholders' funds left on deposit	711,591,795	2
Reserves for dividends, due, declared, or apportioned	446,425,507	1
All other liabilities	851,553,128	3
Total liabilities	$33,893,039,491	100
Capital or guarantee funds	33,965,051	
Surplus	1,747,093,345	5
Assets to cover	$35,674,097,887	

* Advance Printing of Principal Statistical Tables from the *New York Insurance Report*, 1945, p. 31.

items of liabilities (reserves) and the percentage each is of the total liabilities. The capital and surplus are, of course, not liabilities but are included so as to bring a total in each table equal to the total of the corresponding assets. This arrangement also permits a percentage comparison of these items with the liabilities.

These tables show aggregate figures for all types of carriers in the respective fields. Differences in type of carriers, their major field of operations, and their operating policies will cause the percentages to differ when they are worked out for individual carriers. For example, not all carriers set up contingency reserves. Such reserves will generally form a larger percentage of the total liabilities of the carriers that do so than the average figure above, which is diluted by the presence in the aggregate of carriers that do not. Some mutual companies and reciprocal exchanges have guaranty funds corresponding to the capital of stock companies. Others do not but show only one surplus item. Alien companies are required to make a deposit with the state through which they enter as quasi-capital of the United States branch. The percentages of the aggregate of all carriers, of course, reflect only average conditions. The percentages are taken to the total liabilities as this seems more meaningful in this discussion than would be percentages of assets, covering capital and surplus as well.

Accuracy of Statutory Reserves.—There is some redundancy in the statutory reserves. Experience has shown that in most cases the disallowance as assets in the statements of fire and casualty companies of premiums in course of collection more than 90 days past due creates a greater reserve for bad debts than is necessary. More important is the fact that the unearned-premium reserve must be calculated on a full prorata basis. The theoretical justification for this requirement is the clause in the policy which permits the company to cancel but requires it as a condition for so doing to refund the prorata unearned premium. Companies, even when retiring from business, rarely if ever cancel all their risks. They reinsure them in another carrier. Unless the underwriting has been very bad, they are able to reinsure for not more than 70 per cent of the reserve, often for much less than that. This is true, not only because the reinsuring company

usually acquires valuable agency connections, but also because it would have to pay commissions to agents and other initial expenses to procure the business if written direct, and it can therefore afford to pay the reinsured company a similar commission.

There is usually a similar redundancy in life-insurance reserves, but it is not so simple to demonstrate. The American Experience Table is old and, although the mortality at present experienced after age sixty is about that shown by the table, at the younger ages it is much less. As long as the reserves are calculated on a tabular net basis, the reserves by a more modern table, for example the American Men Table,[1] would be generally larger.[2] But the net premiums by the American Experience Table are much higher than necessary. At some of the younger ages gross premiums less than the net by the American Experience Table would provide not only for the mortality cost but also for all reasonable expenses. However, if the gross premium is less than the net by the American Experience Table, the companies are required to set up a *deficiency reserve* in addition to the tabular net-premium reserve. This requirement has prevented the companies, except in rare instances, from reducing their gross premiums charged below the American Experience net premiums. Thus, most companies have in their actual premiums charged a margin in excess of requirements for mortality and expenses. This is particularly true of the premiums on participating policies which are loaded to provide attractive dividends. This margin is disregarded in the reserve basis but, since dividends are not guaranteed, it constitutes a margin of strength of large dimensions.

From the point of view of the policyholder the redundancy in required reserves is probably unobjectionable. It may be an advantage. It tends to show by shrinkage of surplus or impairment of capital that a carrier is in dangerous waters before its condition is so bad that the policyholders' interest cannot be pro-

[1] Based on the combined experience of the leading companies of the United States and Canada from 1900–1915.

[2] For an explanation of why this statement is true the student is referred to technical works on Actuarial Science, for example, Spurgeon, "Life Contingencies."

tected by reinsurance if the bad condition cannot be corrected and the carrier made sound.[1]

From the point of view of carrier management the situation is somewhat different. The requirement of excessive reserves places an additional handicap on the formation of companies by requiring a larger surplus to be paid in. Not only must enough surplus be paid in by the organizers to cover the cost of developing the organization of the company and of procuring for it a suitable agency corps without drawing upon the capital (par value of stock); enough must also be paid in to provide these excess reserves. Furthermore, excessive reserve requirements tend to restrict growth. A carrier cannot afford to grow at such a rapid rate that its surplus cannot furnish these reserve excesses.

Excess reserves do not increase costs to policyholders, for at the expiration of the policy term (*e.g.*, in fire and casualty insurance) there is no unearned premium, and any excess reserve held automatically becomes surplus. Thus, no increase in rates is necessary to permit setting up the reserves. Indeed, increase in rate would not remedy the situation; it would make it worse, since the reserve is based on the premiums.

If there were a dearth of insurance facilities, restrictions on the development of additional ones might be objectionable. Certainly that is not the case in the United States at the present time. Rather, the public is suffering from excessive competition due to overdevelopment in the number of carriers in most fields. Under such circumstances, requirements for more adequate financing of new carriers would appear to be advantageous.

SUMMARY

1. Since insurance obligations are payable in the future while premiums are payable in advance, it is necessary to a true statement of their affairs and fair treatment of successive groups of policyholders that carriers recognize future obligations as lia-

[1] Some failures in recent years with losses to policyholders only partly refute this statement. Analysis of individual cases discloses that dishonesty in management (against which no reserve system is an adequate defense), incompetence in the investment of funds, or failure to set up proper reserves, and failure of state officials to act when they were found short, were the principal reasons for such losses.

bilities. Usual commercial standards of solvency are not appropriate.

2. Liability items in the balance sheet measuring these obligations are called reserves.

3. Reserves may be classified into two types: statutory and voluntary.

4. Reserves may also be classified as those for matured obligations payable in the future and those for obligations to mature in the future.

 a. The first class includes claim reserves and various incurred expense reserves.
 b. The second class includes unearned-premium reserves, the legal reserves of life-insurance companies, and contingency reserves.

5. Claim reserves are for unsettled claims, whether yet made or to be made in the future, and for the deferred installments of settled claims.

6. Expense reserves, except those for claim expense, are amounts remaining unpaid because of services rendered.

7. Tax reserves are for taxes payable in the future because of premiums collected or other similar items. They should be segregated from expense reserves.

8. Reserves should be set up for dividends voted but not paid, and for deferred-dividend funds of life-insurance companies.

9. Unearned-premium reserves enable insurers to meet their obligations to policyholders or to reinsure their business.

10. The legal reserve of life-insurance companies may be looked upon as a reinsurance reserve or as the excess of the present value of policy obligations over the present value of future premiums.

11. The determination of all reserves requires an inventory of the items to be covered and a proper valuation of the several items.

12. The inventories are made from subsidiary accounting and memorandum records. Various grouping methods are used to short-cut the practical work.

13. That statutory reserves are somewhat redundant seems to be advantageous both to present policyholders and to the general public.

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CHAPTER XXV

COMPANY ORGANIZATION

For conducting the affairs of any business enterprise in an orderly and effective manner, a suitable form of organization is necessary, the complexity of which depends on the intricacy of the business. A review of the problems of the insurance carrier as outlined in the immediately preceding chapters should indicate that, to be successful in meeting them, a carefully worked out organization is essential to any carrier. The actual organizations, of necessity, differ greatly according to the type of carrier, the field of its activities, and the type of risks it assumes. The following outline assumes a stock or mutual corporation of substantial size. It will require considerable modification at several points, which it is believed the reader will recognize, if the carrier is a reciprocal exchange or a small stock or mutual company. The outline is a composite picture and does not represent any particular individual carrier or group of carriers.

Source of Authority—Stockholders, Policyholders.—The original source of authority in any business is the proprietor; if it is a corporation, the members of the corporation. If it is a stock corporation, the members are the holders of the stock and their individual rights and powers are measured by the number of shares held. In some of our older stock insurance corporations the policyholders were also given a voice in the management of the corporation, but the practice of making provision for such control is now obsolete and, even in the survivors of the earlier type, the provision is meaningless in practice because never made use of by policyholders. If the corporation is mutual, the members of the corporation are the policyholders, and their respective rights are defined by the charter and by-laws. Sometimes a statement of these rights also appears in the policy contract.

The power of the stockholders or policyholder members is exercised through an annual meeting at which the reports of officers and directors are presented for ratification, and directors

or trustees are elected as provided by the charter and by-laws. In practice, such meetings are usually held by proxy, and opposition to the management is rarely presented. The disgruntled mutual policyholder lets his policy expire and fails to renew, or surrenders it and gets out. Strife between stockholders is usually settled by one faction buying the other out. If the officers and directors do not have the confidence of the stockholders or policyholder members, there is little hope of success for the company.

Directors or Trustees.—The real power and responsibility rest upon the directors or trustees. They are usually experienced businessmen in whose judgment and business acumen those who elect them have confidence. They are often bankers or lawyers, and rarely is even a majority made up of experienced insurance men. Although they are charged with the responsibility for conduct of the company, they usually exercise their duty by selecting men whom they believe competent to fill the executive offices and whom they hold responsible. Certain of the duties are delegated to committees designated as executive, finance, underwriting, office, etc. Usually the more important officers are themselves directors. Theoretically, they are annually elected to the board. They have often come up from junior positions and may have been acting as high executive officers for some time before a seat is found for them by reason of death or resignation of some member of the board.

The board meets periodically, receives reports from the officers and committees, and passes the necessary resolutions for the conduct of the business. In various ways the executives learn what actions would probably be ratified by the board and what actions would be disapproved. Rarely is there extended debate in directors' meetings.

Officers, Committees, Relations.—The officers elected by the directors usually include the *president*, one or more *vice presidents*, a *secretary*, and a *treasurer*. To these are added, usually by appointment of the president, confirmed by the *executive committee* or the board, *assistant secretaries*, a *comptroller*, *assistant comptrollers*, and other junior officers. In the case of a life-insurance company the *actuary* and the *medical director* are sometimes elected by the board. Sometimes the *general counsel* is also an

elective officer. Sometimes the work of general counsel is performed by a law firm under a special retainer. The treasurer usually ranks as a vice president and sometimes carries that title also. Sometimes the general counsel or secretary also has the title of vice president.

In the intervals between the meetings of the directors most of their powers are exercised by the executive committee which, like the officers, is chosen by the directors. Although occasionally this committee may represent powerful stockholder or policyholder interests, it is usually composed of the president, one or more vice presidents, and not more than one or two other directors. In a large degree it is the president's cabinet or council, with whom policies are put in final form for the board's action. There will generally be proportionately much more insurance experience represented on this committee than on the full board.

Determination of the investment policy of the company is usually delegated by the directors to the *finance committee*, of which the president and treasurer are usually members, with one or more of the directors who are particularly skilled in investment matters. The treasurer is the officer through whom their action is carried out.

In addition to these two committees there may be an *underwriting committee* or an *insurance committee* which determines underwriting policies. It will be composed of the president and one or more vice presidents. In the case of a life-insurance company, the medical director or actuary, if a member of the board, will probably be on this committee. In any event they are its close advisers. There may also be an *agency committee* of which the vice president in charge of agency matters will be the chairman, and an *office committee* charged with passing on questions of office management and policy.

The president is responsible to the directors for the conduct of the company's affairs. If there is not a separate chairman of the board, he is chairman. The vice presidents assist him in general or special fields. The committees of the board are designed, not to hamper the action of the officers, but to give the assistance of a smaller body with whom details may be discussed more satisfactorily than with the entire board.

Junior committees composed of groups of junior officers are

sometimes appointed in the larger companies to pass on matters which it would be unwise to delegate to one official, but which are not deemed of sufficient importance to take up the time of a senior executive.

DEPARTMENTAL ORGANIZATION

The duties of the vice presidents and other officers depend in part on the company's plan of organization. This may divide duties on one of several different bases. The basis of division may be

1. Territorial.
2. By kinds of business written.
3. By functions to be performed by the organization.

Sometimes the plan of organization involves division along all three lines.

Where the conditions of competition or supervision require many decisions with regard to operations in particular territory that are independent of matters elsewhere, the territorial basis of division has obvious advantages. Many territorial departments of fire-insurance companies are managed almost as separate companies, with a vice president in charge of each department. Sometimes he is resident in his territory. Sometimes a resident manager is appointed, and the vice president in charge of his territory at the head office, to whom he reports, is the liason officer between him and the company proper.

If the company does several kinds of business, it is not infrequent to find a vice president in charge of each department. Thus one company which does a large life-insurance business, and also a large health and accident business and liability business, had for many years four vice presidents, one as a general associate in the president's work, one in charge of the life department, another in charge of the health and accident department, and the fourth in charge of the liability department.

The functional plan of organization resembles similar plans in other businesses. Each major department such as agency, underwriting, or claims, is in charge of a vice president or other senior executive who is responsible to the directors through the president and executive committee for the conduct of his department. The ultimate responsibility for coordinating departments

lies with the president, but usually there is some form of periodic conference between department heads for consideration of interdepartmental problems. Even when the jurisdiction of the senior executives follows territorial lines or is determined according to kinds of business, the organization is usually along functional lines within each major division, for the specialized work required in each of the major activities necessarily dictates this kind of organization. Often the functional organization will cut across the territorial.

Whatever plan of organization is adopted otherwise, the financial organization usually serves the company as a whole. Under the treasurer, and reporting to him, is the comptroller, who prescribes the form of accounting and manner of reporting and control of finances for all departments. Even when, as is sometimes the case, a department is so managed as a separate unit that it is charged with such common items of expense as forms and stationery, the general system of accounts and records is prescribed by the comptroller at the head office. The reason why this is desirable is that financially the company is a unit, all its assets are available for the guarantee of all its policies, and it is so regarded by the supervising authorities and required to make a consolidated financial report. This could not be done unless the accounts throughout the organization were standardized and unified to that end.

Agency Department.—In a small company a vice president may also have the title of *superintendent of agencies.* As the company grows larger, the vice president may yield that title to one or more assistants. If there is more than one, these assistants may be assigned different territories. Each of these territories may again be subdivided into smaller units. The details of organization from this point depend on whether the company's organization is predominantly on the general-agency, branch-office, or direct-reporting plan.[1] Its function corresponds to that of the sales department in a manufacturing enterprise.

The agency department publishes the house organ or otherwise periodically communicates with the fieldmen to keep them interested in the company and alert in their work. It sets quotas and arranges competitions in production, offering emblems

[1] See Chap. XIX.

and other prizes. It arranges regional and general conventions and generally uses its best efforts to keep and enlarge an alert and active set of producing agents. The methods just mentioned are more characteristic of life insurance and those lines where the agents are closely knit to the company, than of fire insurance and those kindred lines where the agent is more of an independent businessman. In the latter case, calls by a *special agent* take the place of the prize competition, convention, and other inducements.

Recently several of the larger companies have undertaken more general advertising and have employed special publicity managers. These usually work under the direction of the head of this department. In the fire-insurance field, much advertising in insurance journals is given to familiarizing agents with the advantage to them of developing "side lines," such as water-damage insurance and tornado insurance, and the need of their clients for use-and-occupancy insurance. The need of insurance against damage to property is so well appreciated by the public and by moneylenders that there is little opportunity for the agent to increase his business in that line except as new property is created. Hence, these other lines are suggested as an outlet for his energy and the increase of his income without increasing the ruthlessness of competition for the better known lines.

Underwriting Department.—Of necessity, because of the special training and information required, the *underwriting departments* are organized by kinds of business and territory. There is a chief underwriter for each kind of coverage and, except in life-insurance companies where the applications are all passed on at the home office, for each major territorial district. He lays out general plans for passing upon prospective business and himself passes upon the unusual and difficult cases that may be referred to him. He has several assistants of various grades running down to daily-report examiners who inspect each daily report received for conformity to rules and for safety of lines assumed. If the daily report shows no unusual feature, it is passed by the examiner and receives no further attention. Cases raising some question in the mind of the examiner as not in conformity to the company's established practice are properly ticketed and referred to his supervisor for further consideration; they may be disposed of by a junior underwriter or, if he deems it

desirable, passed on to the chief of the division or department. Before cancellation is ordered, the special agent covering the territory is usually consulted.

The chief of the underwriting division keeps in touch with the statistical department and secures regular or special reports from time to time on the experience by classes and districts, revising his line limits and rules in accordance with his interpretation of these data. An important duty of the chief of the department and his leading assistants is service upon committees of rating organizations for the determination of class standards, rules, and rates. In this duty no little responsibility rests upon them for the future of the company, as well as for that of the business as a whole. There must be close and cordial cooperation between the underwriting and agency department.

Accounting Department.—The *accounting department*, under the comptroller, has a staff of accountants, bookkeepers, ledger and other clerks. With companies whose policies are issued by agents, the first step in accounting for income is keeping track of forms, which are numbered and charged to the agents as sent out. As soon as daily reports have passed the examiners, they come to the accounting department for entry in the blank policy registers which were prepared when the forms were sent out. Any break in the order of numbers reported is immediately run down. Brief particulars are entered opposite each number to show the risk. The daily report is then passed on to the files.

When the account current comes in, it is audited by first checking against these records. Then computation of commissions is verified, vouchers for return premiums and other disbursement credits taken by the agent are examined, and, if found satisfactory and the expenditure has been authorized, the credit is passed. When the account is found satisfactory, it forms the basis for entries into the agents' ledgers and other subsidiary books from which the general ledger is posted. Usually the memoranda for punching cards, or otherwise preparing data for determining the unearned-premium reserves, are made from the accounts current. The details vary so much with the size, kind of business, and other conditions of the company that no complete general statement of the work of the accounting department can be made. The nature of the work to be done has been indicated.

In those branches of insurance in which the basis of premium is the insured's pay roll, the pay-roll-audit division is an important part of this department.

When the company operates on a budget system, this department must prepare the preliminary budget and audit disbursements accordingly.

A separate section of this department is concerned with investment accounting. Separate accounts of each investment must be kept so that interest may be promptly collected and a change made if it is deemed desirable. Custody of the securities themselves is usually (nominally at least) with the treasurer. Negotiable securities are usually kept in a vault or in safe-deposit boxes, and the presence of two or more officers is required before access can be had. If the company invests extensively in mortgage loans, it is necessary to keep on file the insurance policies, title records, and appraisal reports connected with each loan. Tickler records must be kept, not only of interest and other payments to be made, but also of the due dates of taxes, and expiration dates of insurance policies.

Actuarial and Statistical Departments.—The *actuary* of a life-insurance company is both a staff (advisory) and line (administrative) officer. He, with the *medical director*, is the chief adviser on underwriting policies. He advises with the legal department in the preparation of forms and recommends methods for apportioning surplus. He prepares the tables of rates and surrender values for policies and advises with the agency department as to appropriate commissions to be paid to agents. Under his direction, statistical studies of experience are made upon which to base the company's future plans.

Administratively, his department determines annually the amount of the reserve liability under its policies of all forms, including annuities, deferred liability under installment claims, and any other item subject to valuation on the basis of expected mortality and interest. In the case of policies subject to loans or other conditions, so that the nonforfeiture values as printed in the policy do not apply, it makes the necessary calculation. When the basis of dividend apportionment has been approved by the directors, it prepares tables of dividends according to age at entry, plan, and duration, so that the renewal premium division

of the comptroller's department may prepare suitable notices and vouchers.

In insurance other than life, the actuary and his department usually play a less important part. Indeed, it is only within the last four decades that the title has come to appear among the officers of casualty companies, and it does not yet appear in the fire-and-marine group. But most companies maintain *statistical departments*, generally as subordinate divisions of the underwriting departments. They keep records and make reports on classified experience for the guidance of the underwriters and where, as in workmen's compensation and a few other lines, the experience of the individual risks is of some value for rate making, such records are also prepared both for the purpose of considering the desirability of renewing expiring risks and for adjusting the rate on the individual risk. With increasing demand for publicity of the bases and processes of rate making, and for statistical control of rates, on the one hand, and the development of better qualified insurance statisticians through technical societies and special studies, on the other, there is reason to believe that the technician working with statistical data, be he called actuary or statistician or by any other title, will gradually come into a more important place in the conduct of the business of insurance in all its branches. This tendency is notable at the present time in workmen's compensation insurance, automobile and other liability insurance, and accident-and-health insurance.

Secretarial Department.—Aside from being the recording officer of the board of directors and its committees, the *secretary* is generally the officer in charge of the records (other than accounting records), files, correspondence, and similar matters of the company. In the secretary's department of a life-insurance company will be found the *division of policy issues* headed by the *recorder*, the *division of policy changes*, the *filing division*, and the *mailing division*. The function of each of these divisions is indicated by its title. Similar duties are imposed on the secretary's department in other types of companies. In a company doing many kinds of business and departmentalized along these lines, there will frequently be a secretary for each department as well as a secretary for the company as a whole. The latter is usually assigned general executive duties with a limited staff

under his personal supervision, the direction of the staff for each department being assigned to the secretary of that department.

Claim Department.—If the company is departmentalized by lines of business, there is a *claim division* within each department, for the manner of settlement of claims depends on the kind of business. If the company is not so departmentalized, there will be divisions within the claim department handling each kind of insurance. Claim settlements must be made in the field by investigators and adjusters working out of the nearest branch office, or by independent representatives, but their work must be closely supervised by the head of the claim department.

To this department fall the duties of selecting qualified adjusters and investigators, training them in their duties, and supervising their work. In the personal insurances it also selects the medical representatives whose examinations determine the degree of disability. This is the work of the medical director[1] of such a company who also passes upon unusual cases to determine whether the claim is reasonable, the treatment given appropriate, and similar questions.[2]

In this department should be kept, either at the home office or at suitable branch offices, claim registers from which outstanding unpaid claims and the amount paid on settled claims can be determined. These should be supported by complete claim files in which all papers on each case are preserved. If a case is one calling for periodic payments in the future, suitable tickler records must be kept to assure that payments go forward as required. There should also be indexes to call cases up periodically for review if the period of payment is not fixed.

No light responsibility rests on this department for estimating the amount of unliquidated claims against the company when financial statements are prepared. In fire insurance and other property insurances, where the claim is payable in one sum, the amount claimed is entered in the loss register as the claim is

[1] The same title is used for the medical adviser of a life-insurance company whose work is essentially underwriting. The reader should endeavor to keep the difference in mind. In some companies the more accurate title *surgical director* is coming into use.

[2] As its name implies this department is concerned with the settlement of loss. It would be well, therefore, for the reader to review at this point what was said in Chap. XXII.

registered. Rarely is there basis for change until the claim is adjusted and paid. On the other hand, it is often impossible to determine even approximately the value of a claim for workmen's compensation from the first papers filed, or until much later. It is the custom in many offices to provide on the file for entry of several successive estimated values, and to review the entry each time a new piece of information is received, as well as at regular intervals. When an estimate of outstanding liability is required, the tickler of open cases may be consulted, the files drawn, and a list of estimates drawn off. Against these the payments made may be offset.

It is often also the duty of this department to summarize the material in the claim files in suitable spaces on the folder for the use of the statistical department.

Special Services.—In many companies there are important service departments. For example, the major work of title-insurance companies is the ascertainment that the title record is clear before the policy is issued. To this end the companies maintain elaborate indices, known as "plants," of the records of the counties in which they do business. Boiler- and machinery-insurance companies make a specialty of inspecting periodically the properties insured, both for the protection of the company and the service of the insured. Most companies writing workmen's-compensation insurance maintain *safety-engineering departments.* Field inspections of plants are made, safety recommendations are presented, and research in safety devices and safe practices is carried on. The statistical department is often called upon for elaborate studies for assistance in this work. The factory mutual fire-insurance companies sometimes speak of themselves as fire-prevention-engineering organizations rather than insurance companies, because of their insistence on high standards before they will accept risks, and because of their researches in fire prevention.[1] All such departments are headed by competent engineers, sometimes ranking as vice presidents in the company.

Supply Department.—The *supply department* is usually under the supervision of the comptroller. It is an important division,

[1] The Underwriters Laboratories, Inc., maintained and supported by the stock fire-insurance companies, carry on similar work.

sometimes calling for the maintenance of a complete printing plant for the printing of policy forms, advertising literature, and other printed matter used by the company.

Personnel.—In the larger organizations personnel work, including maintenance of lunch rooms, recreational and educational facilities, and similar activities, takes up the attention of a somewhat smaller but still important division.

SUMMARY

In this chapter there has been presented an outline of a typical form of insurance-company organization. As the details of organization must be adapted to the activities and ideals of each carrier, this outline will probably fit closely no individual carrier. The aim has been to sketch what might be termed a composite photograph of the various organizations in the insurance field.

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CHAPTER XXVI

COOPERATIVE ORGANIZATIONS

In addition to the organizations engaged in the insurance business as professional risk carriers, many other organizations are found in the insurance world. These are organizations among the companies as such, and among their employees and representatives as such. The purposes of these several organizations are various, but their ultimate aim is common—the advancement of the business and of those engaged in it. An account of these organizations might begin with an attempt to classify the various organizations and citation of examples of each.[1] It may, however, be more enlightening first to consider the circumstances that give rise to the need of the more common types of organizations and to show how they meet this need.

Competition among Carriers.—Attention has already been directed to the necessity of insurance carriers restricting their lines, both on individual risks and on zones or groups, to avoid undue exposure to single occurrences which might result in so great loss as to threaten the continuance of the company. In the case of fire insurance, for example, the greater the congestion the more tightly must the lines be drawn. But it is just in the regions of greatest congestion that the need of insurance is greatest; particularly is this so if the hazard due to construction or contents is great. In our great congested-value centers, New York, Chicago, Boston, Detroit, and other large cities, therefore, the demand for insurance coverage is steadily pressing upon the supply. Hence, since there is little legal impediment to the formation of insurance carriers, there is a tendency for new capital to flow into fire-insurance underwriting. This cause is clearer in the case of fire insurance, but similar forces operate over a wide range of kinds of insurance.

[1] For an example of such treatment see Riegel and Loman, "Insurance Principles and Practices," rev. ed., p. 61.

These risks which stimulate the growth of new companies are the least desirable. To "sweeten" the mass of its business, each new company limits the business it will take from among these risks and seeks an offset in a corresponding volume of business of a less hazardous character. But this is the business for which the present capacity is adequate or more than adequate Hence the keenest of competition for these risks results.

Competition may center on any one of four elements in the practice of the business such as

1. Rates.
2. Policy terms.
3. Agency relations.
4. Service to policyholders.

It has involved and, to some extent, still involves all. Although competition has in some respects resulted to the advantage of the public without injury to the carriers, as in the liberalization of policy terms in life insurance, unrestricted competition along any of the first three lines results in the destruction of the weaker competitors and has a tendency to weaken public confidence in all carriers and in insurance as an institution. In the public interest such competition must be restricted within reasonable bounds, either by state compulsion or by voluntary action. This has always been understood by the wiser of those engaged in the business, but not by all nor by the public. In the earlier history of the business, the public attitude was to rely upon competition as the proper regulative, and to encourage it and suppress all efforts at its restraint. This attitude is still existent in certain quarters, where state policy is still to encourage and enforce competition but, in the more advanced communities, the fallacy of this view has become increasingly clear, with a corresponding tendency to encourage restriction. Severe regulation has been the result in other communities and has been found so burdensome by the carriers as to be resisted with all the power they can muster.

Control through Cooperation.—The logical ideal is control of such competition through cooperation, and efforts have long been made for this, even in the face of most serious opposition.

This opposition has been of two kinds:

1. From the state where the state policy has been to rely on competition as the protector of public interest.

2. From those newly venturing into the business whose growth and development has been handicapped by restriction; or from those bold spirits who cannot brook opposition, and who tend ruthlessly to sweep away all obstacles to the realization of their dreams, whether or not those dreams are wholly selfish.

Perhaps there should be added a third group, those who are not strong enough to fight for their own ideal against the pressure of associates, who either cannot see the ideal or insist on a selfish defense of what they regard as their own interests even if they see it. Many an executive, because of the threatened loss of valuable agency or other connections to his less scrupulous competitors, has felt forced to repudiate agreements to which his own judgment gave ready assent. The lack of authority[1] of the national government to deal with insurance problems, and the diversity in conditions and policy between the several states, add to the problem.

It must also always be borne in mind that, except in the mortality tables in life insurance, there is no bottom figure, similar to the cost of material goods offered for sale, against which individual prices may react. The cost of furnishing insurance, as has been pointed out before,[2] is not ascertainable until after the contract has been made. Hence, the only natural limit to the competitive force is the optimism of the most reckless.

Rate-making Organizations.—Rate-making organizations are usually confined to a single kind of insurance, such as fire insurance, or to closely associated lines. For example, the Board of Fire Underwriters of the Pacific, which is principally devoted to fire insurance, also acts for its members in fixing rates for earthquake insurance. If several kinds of insurance come under the jurisdiction of a single organization, each line is usually cared for by a separate department or division. For example, the National Bureau of Casualty and Surety Underwriters makes rates for several kinds of casualty insurance, each being assigned to a separate department.

[1] Under the decisions of the Supreme Court prior to 1944.

[2] See Chap. XX.

Cooperative control of rates and practices is so vitally necessary to the business that, where combination has been interdicted by statute, subterfuges have been resorted to in order to circumvent the legal prohibition. The most common subterfuge has been first to dissolve the cooperative bureau, then to encourage the former manager to set up as an independent rate expert offering his advisory rates to any who care to purchase them at prices fixed to cover his expenses and a margin to himself about equal to his old salary. The companies formerly members of the bureau have then uniformly contracted for this service. Sometimes laws have been amended to prevent the use of this device, and the companies have been heavily fined. Even when these laws have been successful, the companies have generally been able to prevent rate wars and to stabilize rates fairly well.

The more recent tendency in state policy has been to recognize the need of cooperation in rate making and to require by law membership in a rating organization for each territory in the state in which a carrier operates, making adherence to its rates and rules mandatory. The organization operating under such a law is subject to state supervision to prevent unfair discriminatory practices, but it is not objectionable. It has the great advantage of the force of law to keep in line the strong man who lightly regards obligations of the kind that do not seem to him to advance his interests or ideals, as well as the less experienced manager whose apparent boldness is the result of inexperience.

In such organizations the source of authority is a governing committee of carrier representatives elected at the annual meeting whose major duty is the selection of the manager and the levying of assessments on the companies for the maintenance of the bureau. If there is no other grievance committee, it falls to this committee to hear complaints and administer discipline. If membership in a bureau is compulsory and if the bureau is exclusive for its territory, serious grievances are usually referred to the insurance commissioner. Sometimes the governing committee has legislative power, but usually important legislation for the government of the bureau may be passed only by the full membership at annual or special meetings.

The technical problems of classification rules, rate derivation from statistical data, systems for modifying the manual rules on

the basis of physical condition determined by inspection, the application of schedule or experience-rating plans, and other problems of similar nature are usually subject to the control of committees of carrier members on which the carriers are represented by their own technical experts in the work involved. In some of the bureaus of national scope, regional committees of representatives of carriers with unusually large interests in the state or states covered make the final decision on rates and rules for the several regions. If the bureau is exclusive and membership compulsory, so that it has quasi-official standing, the insurance commissioner or his representative may sit on the committee and vote, though usually he prefers to reserve action and exercise a veto power when necessary.

Although legislative power in such matters rests with the several committees, the preparation of recommendations to the committee and the carrying out of its decisions rest on the staff of the bureau under the direction of the manager. For this purpose the bureau has a staff of technical experts with equipment and clerical assistance. In the field of workmen's compensation insurance, where different classes of carriers are members of the same organization, an effort is usually made (sometimes it is required by the constitution) to balance the different interests in committee representation. Sometimes apparently minor differences in the phraseology of classifications may gravely affect the business of one or more carriers, or a difference in interpretation of rules considerably change the cost of insurance to large business enterprises. In such a situation there is almost invariably appeal from the decision of the management, and sometimes prolonged debate in committee.

Where membership is not compulsory on all carriers and there are competing carriers offering to write risks at lower rates or on terms or conditions not approved by the bureau, a serious situation is created for the bureau or board companies, and there may be threats of revolt and disintegration. No remedy has so far been discovered, save a suspension of rules and authorization to meet competition. This is a dangerous remedy and sometimes brings about the very thing that it is designed to prevent. When this happens, a new organization is brought about, after a more or less extended period of unrestricted competition.

In some kinds of insurance, revision of basic manuals of rules, rates, and classifications is relatively frequent, as new statistical data are secured, or the risks covered are changed. For example, the more or less constant tinkering with workmen's compensation laws, and the development of new processes and machinery, make inevitable the constant revision of rates for workmen's compensation insurance. The situation in automobile insurance is similar, owing to such factors as increasing congestion of cars, changes in types of cars, and new roads and road rules. However, there are fields, such as fire insurance, where the basis systems of rate making, classifications, and rules change only at relatively long intervals, although in the meantime changes may be made in rates for individual classes or groups of classes; *e.g.*, towns may be rerated.

In addition to the preparation of basic or class rates, these organizations make rates for individual risks by applying the schedule or experience-rating plans, and promulgate such rates to their members. Usually they check the application of the rates by passing upon daily reports before they go to the company offices. Those not found in accordance with the rules are returned for correction of the policy. Those approved are so stamped, from which practice this part of the bureau is known as the *stamping office.* Sometimes, to facilitate business, a bureau having jurisdiction over a considerable territory will have branch stamping offices in several places.

The bureaus and stamping offices are concerned not only with rates but also with forms and endorsements. Advantages equivalent to large rate reductions may be allowed by attaching, without suitable extra charge, various endorsements amending the standard contract. The bureaus, therefore, prescribe the contract forms and the riders and endorsements that may be used, where they are not required by law. Usually they do not print the forms.

Standard-forms Bureaus.—More recently the companies in some lines of insurance and in several jurisdictions have found it profitable in view of the complexity of statutory requirements as well as bureau requirements to provide for cooperative printing of endorsements and other needed forms. This provides stand-

ardized forms and reduction in printing costs, the bureaus being nonprofit organizations.[1]

Organizations Regulating Agency Relations.—The insurance rate must provide for expenses as well as losses, and it may become inadequate by reason of excessive expense, even though amply adequate for the losses and expenses contemplated when it was made. Regulation of expense is, therefore, a corollary of rate regulation.[2] Sometimes this regulation of expense is undertaken by the organization that makes rates. Sometimes it must be undertaken by an organization of broader scope. Head-office expense generally is kept down by the officials, and competition rarely, if ever, tends to increase it. The largest expense item, and the one most difficult of control, is *acquisition cost*, the expense of selling.

At first sight it would not appear difficult to fix and adhere to a scale of commissions to agents and, if all agents were of the same class, it might well be a simple matter. But even in a particular line of business there are many classes of agents in different regions whom it would not be fair to remunerate on a uniform scale. Some agents may write no policies and keep no records, merely sending in applications and receiving and delivering policies as an incident to other business. Others issue policies and keep elaborate records. The latter should receive at least enough more than the former to cover their office expense. Some general agents conduct the entire business of the company, producing little direct personal business, but securing much through local subagents and brokers. They assume for the company the function and cost of building up the organization in their territory and supervise through special agents. Others produce considerable personal business as well.

One company may furnish office rent or an allowance for it, or make an allowance for stationery or telephone or other service which will make a low commission scale more attractive. Desk space and other facilities for brokers are means of compensation in addition to commission.

[1] The forms quoted in Appendices II to XI were furnished through the courtesy of three such bureaus.

[2] It has been held to be within the police power of the states. See *O'Gorman & Young v. Hartford Ins. Co.,* 282 U.S. 251 (1931).

Even though a company adhered rigidly to agreed commission scales for the several classes of agents and brokers and offered no other inducements, it might secure a competitive advantage over another by appointing, in a given territory, more agents in the higher rated (general or regional) classes. It might secure such an advantage even by having more ordinary agents. Thus reprisals and commission wars might be brought about.

Sometimes excess agency representation arises through causes not readily forseen. For example, a company may have had a bad experience, and the management may desire to reinsure and liquidate. Another company may have no great desire to take over the business but may do so to avoid a failure and a blow to the business as a whole. It finds that the weakened company has a valuable set of agency connections. Perhaps this will give it an entrance into new territory. The value of these connections may be so great as to offset the probability of placing a few bad risks on the books and may make it practicable for the reinsuring company to pay a commission for the business as an offset to the full unearned-premium reserve. In several communities where it has been well represented for some time it may find itself with an additional representative, who has been turning in a substantial volume of good business to his former company. It did not intend to have such dual representation, but it has it and, with it, a competitive advantage.

Perhaps the reinsured company will not be liquidated, but stock control or its entire stock be bought by the reinsuring company, and a contract made for continual reinsurance of all risks in full, so that the reinsured company becomes an operating dummy. Then nominally there is no dual representation. Actually there is. To meet this a competitor may issue policies in the name of "The ———————— Underwriters" all policies being guaranteed 100 per cent by it or jointly by it and another company under the same control. Such schemes are known as "underwriters annexes" and are not uncommon in the fire-insurance business. Unless the law interferes, the number of annexes may be multiplied indefinitely.

Regulation of acquisition expense, which must take into account all such practices and factors, becomes a very complex problem and requires elaborate rules and a system of committees

to adjust disputes. Where the law gives the insurance commissioner jurisdiction over such matters, he may require the carriers to cooperate in formulating such rules. If he finds them reasonable, he may then adopt them as requirements and use his official power to enforce them.

Agents' and Brokers' Organizations.—Except where the law prescribes particular qualifications for agents and brokers, it is very easy to become an insurance agent. All that is necessary is to convince some company or special agent that the candidate can turn in a profitable line of business. If he is not conscientious in his business transactions, he may bring disrepute, not only on himself and his company, but on insurance agents and brokers in general.

In the present day of organization, there are, in all the larger communities, associations of agents or brokers (sometimes separate, sometimes combined) for the purpose of bettering their business life. These may be along special lines, as are the life-underwriters associations, or general in their nature. The local organizations are consolidated into state organizations and the latter into national.

The organizations aim

1. To eliminate the unfit from the ranks of brokers and agents and to that end to secure strict agents' qualification laws.

2. To eliminate part-time agents whose main business may be that of lawyer, apartment-house owner, or bank official, and whose aim may be to secure the commission on his own or his family or clients' insurance, or through the coercive power of credit to compel the placing of borrowers' insurance so that he will receive the commission.[1]

3. To secure for themselves what they believe proper treatment from the companies. A major part of the latter aim is continuance of the "American agency system" by which appears to be meant recognition of the agent as a quasi-independent business-man with a proprietary interest in the business he attracts, and ownership of the "renewals," *i.e.*, the record of expiration dates of current policies which is, of course, of great value in canvassing for renewal.

[1] Combination of an insurance agency with a real-estate business seems to be generally recognized as an established legitimate practice.

Agents, being local citizens, and the companies generally foreign corporations, the former have been able to secure in many states "resident agents' laws," requiring all policies issued in the state to be countersigned by, and a commission paid to, a resident agent.[1] The local power of agents' organizations was exemplified recently in New Jersey where, the companies proposing to make a reduction in the scale of commissions in certain counties, the agents succeeded in having introduced, and passed over the governor's veto, a bill requiring each company to pay uniform commissions throughout the state on the same class of business. The organized power of agents and the recognition of renewal rights tend to prevent reduction in commission scales by voluntary arrangement between the companies, except in compliance with legal requirements.

Often, fairly good control of competitive conditions can be secured by the companies dealing with the organized agents through the rating organizations. The organized agents and brokers usually control in various ways much of the preferred business. By agreeing to do business only with agents or brokers who are members of the agents' association or brokers' exchange, as the case may be, the companies may secure reciprocal agreements not to place business with "nonboard" companies or at least not to place business with companies not maintaining "board" rates and practices.

Intercarrier Organizations for Other Purposes.—Cooperation between insurance carriers is advantageous in the solution of problems other than those for which the organizations heretofore mentioned are designed. Organizations dealing with these problems are sometimes associations of companies, sometimes corporations organized for service rather than profit, the entire stock of which is held by the companies.

An example of the latter is the Underwriters' Laboratories,

[1] Since the Supreme Court has held insurance to be commerce, this type of law has been challenged as an improper interference with interstate commerce. The matter has not been taken to the Supreme Court. A lower federal court has upheld such a law. Many thoughtful insurance men question the wisdom of such laws and believe that in the long run their effect will be adverse to their present beneficiaries, the local agents. The agents as a whole do not agree. The author thinks that the agents are mistaken.

Inc., which has an establishment in Chicago adapted to its work as a research institution in fire prevention. It tests all sorts of preventive and protective devices, granting its label, of which there are various grades dependent upon the success in meeting the tests, to devices that are approved. Charges for testing services defray most, if not all, the cost of operation. The factory mutual companies operate a similar laboratory in Boston, specializing in their particular problems.

Other examples are *salvage companies* and *adjustment bureaus.* The former undertake to recondition and sell goods that have been damaged and taken by the company at the appraised or agreed value. By specializing in this work and acting for many companies they can get better results than any individual company. Adjustment bureaus maintain corps of competent adjusters at strategic points in the territory they serve. The services of these adjusters are available to the companies for appropriate charges. This makes unnecessary sending several adjusters to represent the companies involved in a loss when the work can be better done by one man representing all. It reduces the number of adjusters each company must have, as well as traveling expenses.

Salvage corps, operating as fire patrols, hurry to fires, spread water coverings, and otherwise protect goods before the arrival of the municipal fire department. These are usually maintained by intercarrier organizations.

As a protection against the frauds practiced on insurance companies, information bureaus for exchange of information on rejected applications or fraudulent claims are maintained. Some of these are maintained by separate corporations, some by unincorporated associations.

Research Organizations.—Mention has been made above of the Underwriters' Laboratories and the laboratory of the factory mutual fire-insurance companies. Much research goes on in these laboratories in addition to testing products and devices for certification. Other research is carried on cooperatively, sometimes through rating organizations and sometimes in separate organizations set up for the purpose. Typical of these is the Life Insurance Sales Research Bureau supported by life-insurance companies for studying such problems as the cost of building

various types of agency systems and the returns to be expected from the expenditures involved. Its service is in general confidential to its members.

Legislative Bureaus.—Since insurance has until very recently been held not to be commerce and therefore not subject to federal control, and since few insurance companies are domiciled in any one state and must do business in several states, it is necessary for each company to watch legislation in all states and use its influence to prevent unwise and impeding requirements. The first is an expensive task, and the second cannot generally be done effectively by each company acting alone. It is much more economical and effective to handle such matters through an association. This manner of acting also conserves the time of legislators, since it is much easier to listen in a committee hearing to the argument of a single representative of a group of interests than to the individual arguments of the several representatives of the individual carriers. In the present day of publicity of expenditure for lobbying purposes no objection should be raised to this practice. Each group affected by any legislation is entitled to a hearing.

In the field of fire insurance, the National Board of Fire Underwriters represents the fire-insurance interests. The Life Insurance Association of America and the American Life Convention represent the life-insurance carriers, and there are similar organizations in other fields. These are generally unincorporated associations. They also serve as general publicity organizations and as a means of bringing together individual interests for interchange of views on many other matters. For example, the National Board maintains an extensive organization for assisting the constituted authorities in the suppression of arson. It also has a corps of engineers who make fire-hazard surveys of the cities and larger towns throughout the country, turning in grading reports which are used by the regional rating organizations. The reports, including recommendations, but without detailed rating figures, are printed and distributed to city authorities, chambers of commerce, libraries, and other interested bodies. The Board also collects nationwide statistical data on fire losses.

Educational and Professional Organizations.—In addition to the strictly intercarrier organizations for the control of competition, performance of a common service or otherwise advancing

the common interests of the carriers and their representatives, there are other organizations of persons connected with the insurance business which are educational and professional in their nature. Membership in these organizations is personal, though some provide for sustaining memberships by the companies.

The oldest of these are the actuarial societies, whose membership is in two grades: *associate* and *fellow*. Entrance to the first, and lower, grade is conditioned upon passing comprehensive examinations in the elements of actuarial science. Advancement to fellowship is conditioned on passing similar examinations in more advanced work though under conditions set up in their constitutions, other evidence of competence is sometimes accepted or required. Other organizations in different branches of insurance have been formed along similar lines, though they have not yet reached so high a development. The meetings of these societies are forums in which the technical problems confronting the profession are discussed; in their journals are published many of the studies by which the professions are advancing. No effort is made through these societies to formulate or influence directly company policies or actions, but the higher the standing of the society, the more influential will be the papers and discussions published. In connection with the periodic meetings, there are opportunities for personal contacts and friendships which often have great influence on business practices. It is not intended to imply that the societies are used to bring about results by gentlemen's agreements which it might be improper to attempt openly. Their standards are far too high for anything of the kind to be thought of.

Such societies have contributed to developments of technique which have been responsible for much improvement in office practices. Exchange of information has often led officials to realize that contracts could be liberalized without danger, or the field of their activities safely extended. The influence of such organizations has been wholly beneficial to all concerned.

There are some organizations outside the field of insurance itself which the companies foster and sometimes assist financially because of the benefit that they believe will result from them. One example of such an association is the National Fire Protection

Association, whose membership is largely of city fire chiefs and bodies interested in the prevention of fire loss.

Insurance Institute of America.—Up to about 1900 young men in insurance offices were instructed in their own company's plans and ideas but had not much opportunity for broader study of the business. Following the pattern of men similarly situated in Great Britain, a number of organizations were formed about that time for maintaining a library and fostering study groups, *e.g.*, The Insurance Society of New York, The Insurance Institute of Hartford, The Insurance Library Association of Boston. In 1909 a federation of these organizations was formed which is now the Insurance Institute of America, Inc. The Institute plans courses of study in the several branches of insurance. These are conducted on a classroom basis by the local societies. The Institute offers correspondence instruction. Annually it gives examinations held in local centers under the supervision of the local societies. On passing the full set of examinations for one branch the student is admitted as an associate. Fellowship is granted upon submitting a satisfactory thesis in some field. Fellowship is also granted on an honorary basis to executives and others approved by the Board of Governers.

American College of Life Underwriters.—In 1927 a Congressional charter was granted the American College of Life Underwriters which was sponsored by the National Association of Life Underwriters and has its headquarters in Philadelphia. Its object is to bring competent life-insurance agents up to a professional standard and status similar in their field to that of the C.P.A. in the accounting field. It is authorized to confer the designation of Chartered Life Underwriter (C.L.U.). It operates much like the Insurance Institute. It does not give courses but lays out course requirements and other qualifications for its designation and sets the examinations. It arranges with universities throughout the country to give (mainly in extension and other evening classes) the courses required and to conduct its examinations. The C.L.U. designation has come to be very highly regarded among life-insurance men.

American Institute for Property and Liability Underwriters.—The success of the American College of Life Underwriters and other forces led to the incorporation in 1942 in Pennsylvania of

the American Institute for Property and Liability Underwriters, Inc., under the sponsorship of national organizations in both fields, mutual as well as stock, and of the American Association of University Teachers of Insurance. It offers the designation C.P.C.U. (Chartered Property Casualty Underwriters) on conditions similar to those for the C.L.U. and conducts its work similarly. Its field of work is among agents, brokers, and employees of carriers in the fields of insurance other than life insurance.

American Association of University Teachers of Insurance.—Regular courses in insurance, other than those in actuarial mathematics, began almost simultaneously about 1904 at the University of California and the University of Pennsylvania and have been given at both institutions continuously since. At about the same time sporadic lectures on insurance topics were given in other institutions, but university teaching of insurance made headway only slowly until after 1920. Since then the growth has been fairly rapid. In 1932 the American Association of University Teachers of Insurance was formed. Its name suggests its purpose as an academic forum for the exchange of ideas. While maintaining academic objectivity in its point of view, it has, perhaps more than other academic groups, kept contact with leaders in all branches of the business and from all types of carriers.

Social Organizations.—There are other organizations of a purely social character, qualification for membership in which is a particular type of position in the insurance business. The names of some of these organizations and of their principal offices imply fun and nonsense as the prime motive. The author cannot speak as a member but is under the impression that the implication is correct. Yet the serious student of any business or society will fail much in understanding its ways if he ignores the results in practical affairs of personal contacts made and maintained through such organizations.

It has been impossible in this chapter to give detailed descriptions of all types of organization among the corporations and individuals engaged in the insurance business. It is believed that the main types have been indicated and enough said of their purpose to enable the reader to follow through understandingly a more intensive study of any of them.

SUMMARY

1. Competition between insurance carriers is very keen because the concentration of values subject to risk in some places far exceeds the available underwriting capacity, tending to cause the formation of new carriers, which, in turn, causes great excess of underwriting capacity in the less congested regions.

2. Competition may center on rates, policy terms, or agency relations, or any combination of these elements.

3. Unrestrained competition is injurious to carriers and public alike.

4. Control of competition through cooperation is logical, and efforts have been to bring it about in spite of many difficulties.

5. Cooperative rate-making organizations are essential in most lines of insurance and have generally been maintained by subterfuge when anticompact laws interfered.

   a. Such bureaus are governed by committees of carriers, but the technical work is usually carried on by a paid staff of technical experts.

   b. Where there are competing nonorganization carriers, no method has been found for meeting the situation save suspension of rules as to the risk or risks on which the competition arises.

   c. Such organizations also frequently administer rates and to that end maintain stamping offices for reviews of daily reports.

6. Standard-forms bureaus have been found economical and have other advantages, particularly in securing uniformity.

7. Regulation of agency relations is one of the most important, as well as difficult, problems confronting the carrier organizations, because they must harmonize and adjust equitably a great variety of systems of agency representation and remuneration.

8. There are local, state, and national organizations of agents and brokers for the purpose of maintaining codes of ethics, dealing with the carriers, and otherwise bettering their business.

9. Cooperation between company rating organizations and agents' and brokers' associations is frequently resorted to as a means of controlling competition.

10. Other intercarrier organizations exist for performing different special services: testing, salvaging, adjusting, etc.

11. Legislative bureaus, as intercarrier organizations, can present the carriers' point of view more fairly and effectively and at less expense than can the companies individually, and are found in all branches of insurance.

12. Educational and professional societies exist in most branches of the insurance business and are encouraged by the carriers. Membership, however, is usually personal, and sometimes attained only after passing severe examination. Such societies have done much in an indirect way to improve the conduct of the business.

13. Purely social organizations of specialists are also found, contacts within which tend to soften the acerbity of competition.

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Part V

STATE SUPERVISION OF PRIVATE INSURANCE

INTRODUCTION TO PART V

The preceding parts of the text have dealt with the business of insurance, its purpose, method, and problems, from the point of view of the insurer and the insured. It is the purpose of Part V to explain how the state came to exercise regulatory powers over insurance, the purpose, form, and method of regulation, and its advantages and disadvantages. Taxation of insurance carriers will also be considered.

CHAPTER XXVII

DEVELOPMENT AND THEORY OF STATE SUPERVISION

It has been said that the business of insurance in the United States is subject to more governmental regulation than any other. Though this statement may not be strictly accurate, it is true that insurance is subject to a high degree of regulation. There are several reasons, namely,

1. The complexity of modern economic life is so great that the public tends increasingly to delegate to the state the investigation of those with whom it does business, and the elimination of the unworthy, a function which, under simpler conditions, the individual performed for himself. The insurance business feels the effect of this development to a greater degree than most other branches of business.

2. The insurance business and its practices are somewhat of a mystery to the uninitiated. The language of insurance and its processes are of a technical nature and require study and experience if they are to be clearly understood. The opportunity for

the shrewd speculator to take advantage of such a situation seems to call for public action to protect those needing the service of insurance. In particular, looking upon the contract as a contional deferred promise to pay, protection is needed against unfairly drawn policies and dissipation of funds needed to meet contract obligations.

3. Most insurance carriers do business in several states, yet by decision of the United States Supreme Court, insurance was, until 1944, held not to be commerce within the meaning of the interstate commerce clause of the Federal Constitution, and each of the states therefore had the right to establish its own regulations.[1]

4. Abuses have occurred in the conduct of the business and, as they have been disclosed, new regulations have been sought in an effort to correct them.

The above reasons are general and apply to all fields. The peculiar conditions in certain fields creates further need for regulation and supervision:

1. Life-insurance contracts are for long terms and, therefore, the need for careful and adequate provision for the deferred obligation is especially important.

2. The beneficiaries of life insurance and of workmen's compensation insurance are third parties who have no voice in making the contracts and are often not in a position to care for their own interests.

3. Workmen's compensation insurance is really social insurance in which society through the government is definitely an interested party; automobile-liability insurance required by financial responsibility laws is scarcely less so.

4. Group life and disability insurance have wide social implications as does the insurance of employee's pension plans under group annuity contracts.

Clearly, the state has a definite interest in the terms of such contracts and the manner in which they are sold and carried out, including financial provision for deferred liabilities under them.

[1] See *Paul v. Virginia*, 8 Wall. 168 (1868); *Hooper v. California*, 155 U. S. 684 (1894); *New York Life Insurance Company v. Deer Lodge County*, 231 U. S. 495 (1913). Reversed in *U. S. v. South-Eastern Underwriters Association*, 322 U. S. 533 (1944). The effect of this decision is discussed below.

Regulation of Marine Insurance in Medieval Europe.—The attitude of the medieval church toward usury was a handicap to the growth of insurance, since the church classed insurance, as well as the payment of interest, among those transactions in which payment was exacted without the rendering of visible service. It is said that a papal decree of 1227 prohibited bottomry loans, the precursor of the modern insurance contract.[1] It was also regarded as immoral to insure, as presuming to interfere with the ordinances of God. Despite these interferences, however, the needs of commerce forced recognition of the practice. Its abuse for gambling purposes and in commercial rivalries led to the first regulatory legislation. Genoa, in the last quarter of the fourteenth century, passed an ordinance designed to prevent insurance on foreign ships.

The earliest known insurance code was promulgated at Barcelona in 1435. It was apparently in response to the second reason for regulation noted above, for it contained rules as to the conduct of those making insurance and providing that those "who write policies shall be bound to see that they are properly drawn." The problem of securing the solvency of the insurer at the time of loss does not seem to have been dealt with, perhaps because the insured were generally merchants accustomed to investigate the credit of those with whom they dealt. Florence, in 1532, provided for appointment of commissioners to regulate the practice of marine insurance in many details, including rates. There was similar regulation in other cities of continental Europe.

Lack of Governmental Regulation in England and Her Colonies.—The early traders in England, being foreigners, did not usually resort to the constituted courts but seem to have regulated their own practices. Thus there was no occasion for governmental action in insurance matters, although an official registrar of insurance contracts was appointed about 1574 as a private monoply, and a special court for trying insurance cases was set up in 1601.[2] The registration office seems to have been ignored, and the court had little influence on the development of the business. Until the time of Lord Mansfield,[3] insurance

[1] Hoffman, F. L., "Insurance Science and Economics," p. 145.

[2] 42 Eliz. Chap. 12.

[3] Chief Justice of the King's Bench, 1756–1788.

disputes rarely came into the English courts. The first English insurance corporations were chartered in 1720 and were given a monopoly of *corporate* underwriting of marine risks. The monopoly lasted a century. Aside from this monopoly and statutes against wagering, governmental regulation of insurance did not exist in England or her colonial dominions in America prior to the war for independence.

Beginnings of Regulation in the United States through Corporation Charters.—There are records showing the practice of insurance in colonial times by individuals after the manner of the Lloyd's underwriters but, aside from one or two local mutual fire-insurance companies and the Presbyterian Ministers' Fund, issuing survivorship annuities, there were no insurance corporations. However, beginning with the incorporation of the Insurance Company of North America by act of the Pennsylvania Legislature, Apr. 14, 1794, the close of the eighteenth and the beginning of the nineteenth centuries witnessed the incorporation of a number of companies. These were all incorporated by special charters granted direct by the legislatures and, although these charters were by no means uniform, they generally contained some regulatory provisions. These provisions referred to the capital of the corporation and the manner of investing its funds and frequently required reports, either to the legislature or to some designated state official, as the Secretary of State, Treasurer, or Comptroller. Sometimes a deposit of securities with a state official was required. A frequent provision was a requirement for periodic publication of reports of financial condition. No official was regularly charged with the duty of examining these reports or the practices of the companies until much later. The intent seems to have been to provide a means by which those interested might inform themselves. Presumably, it was thought that the avoidance of unsound insurers by prospective customers would automatically cause the death of such corporations, and that those discovering fraud would make complaint to the usual officers of the community charged with suppressing crime. This attitude was in accordance with the individualistic spirit of those times.

There was, however, interference in one respect in several of the states early in the nineteenth century. Pennsylvania and

South Carolina, in 1810, and New York, in 1814, passed statutes prohibiting under severe penalties the writing of insurance for insurers of foreign countries. The apparent motive for these enactments was less the protection of the citizens than enmity toward the British, who were the leaders in the business of insurance.

Taxation and Licenses for Revenue.—Since the insurance carrier must always develop considerable revenue and accumulate a substantial amount of assets, it was inevitable that these revenues and assets should attract the attention of those seeking revenue for the state. In 1824, New York imposed a tax of 10 per cent[1] on the premiums received in that state by fire-insurance companies incorporated in other states in the union. New Jersey began taxing premiums in 1826. As early as 1830, Connecticut began taxing the stock of domestic companies. And in the decade 1841 to 1850, several of the states began requiring the licensing of insurance agents and charged a fee therefor. All such taxation measures required periodic reports for the purpose of determining the tax. The returns were made to a financial officer of the state. Where agents paid a license tax and companies of other states were represented, it was a natural transition to require some sort of showing as to the financial condition of the company.

By the middle of the nineteenth century, several of the states had passed general incorporation statutes covering the several classes of insurance carriers, and thereafter in those states incorporation by special legislative enactment was discontinued. These general statutes provided for filing certain papers with state officials, the minimum amount of capital required, and the manner of its investment. But at that time there was in no state an official charged with the exclusive duty of regulating the insurance business or enforcing the insurance law. There were provisions for special examinations at the instance of the courts, and the treasurer, comptroller, or other official might scrutinize the company reports, if he found time from his other duties. But it was not systematically done nor expected. The next step was the establishment, in certain states,[2] of commissions

[1] Reduced in 1837 to 2 per cent and applied to marine companies as well.
[2] New Hampshire, 1851; Massachusetts and Vermont, 1852.

whose duty it was to examine the reports of the companies and to endeavor to exclude the insolvent. These were generally ex officio boards and, where the duties of the office of each member absorbed his major interest, nothing of importance could be expected.

This gradual increasing of the state's observation and interference in the conduct of the business arose, as did most of the subsequent measures of regulation, primarily from the occurrence of abuses in the conduct of the business. The presence of the policeman on the corner does not prevent all crime, but it does conduce to the safety of the neighboring property. So state supervision and regulation have not prevented, and probably never will prevent, all wrongdoing in the insurance business, but they have prevented some, and stopped other evils, before the maximum injury has been done. It is well, therefore, to consider at this point the opportunities for abuse in the conduct of insurance, which supervision is intended to eliminate, and some examples of abuses before legislation and supervision closed the door.

Abuses—Actual and Potential.—The earliest abuse, for which special legislation was provided even in medieval Europe, was the drawing of improper contracts. Attention has been called to the unfair practices in drafting fire-insurance policy forms before standard forms were prescribed.[1] Reference has also been made to unfair provisions in life-insurance policies prior to 1906,[2] and to similar abuses in personal-accident insurance.[3] The contract is one phase of insurance in which abuses preventable by supervision are possible and have occurred.

Closely akin to abuses in drawing contracts is failure to carry them out in good faith, or unfair discrimination against those who cannot afford the expense of defense of their rights in the courts. Nowhere is the insurance commissioner's office a legal-aid bureau to assist the needy in prosecuting actions against insurance companies, but the power of supervision and publicity can do and has done much to curb unfair treatment and, if to that is added the power of exclusion from future operations, such misconduct is likely to be much less frequent.

[1] Chap. VI.
[2] Chap. X.
[3] Chap. XI.

Failure to make proper provision for paying losses through adequate reserves is an abuse which only careful scrutiny of reports and examination of records can disclose. Such scrutiny and examination must often be by competent technicians before it can be known whether the reserves are adequate.

Improper investment of funds, or even reckless speculation, is possible, if the management of a carrier is unskillful or corrupt, unless suitable safeguards are prescribed, with adequate examination and other supervision to enforce them. Many examples of such misconduct could be cited from the records of carriers whose unworthy careers are happily over.

There are, of course, many insurance carriers whose establishment antedates the practice of any substantial supervision and whose records are unsullied by any of these practices. This might have been expected, as such abuses naturally lead to failure. High ideals of management are a better safeguard than state supervision. But in a competitive world high ideals sometimes have hard sledding. Honestly conducted carriers find in state supervision a considerable measure of defense, even though some expense or trouble in making reports and undergoing examinations may be involved.

Publicity Alone Not a Sufficient Safeguard.—It has been noted that, prior to the establishment of state insurance departments, reliance was placed upon publicity of accounts as a means of protecting the public. The establishment of departments indicates that publicity alone did not protect. Since publicity of accounts has long been the substitute for regulation in Great Britain,[1] whose insurance institutions are recognized throughout the world as of the highest standing, it is well to consider why that system will not work well in the United States.

It should first be noted that, in Great Britain, the manager's freedom of judgment in setting up reserves and handling finances is accompanied by a rigorous enforcement of responsibility for the truth of reports filed with the Board of Trade. This is the

[1] Under the Winding Up Acts 1933 and 1935 the Board of Trade is given power under certain circumstances of investigation to determine solvency. This and certain recommendations in July, 1937, of the Committee on Compulsory Insurance seem to indicate a trend in British thinking toward more positive regulation.

form of publicity that applies not only to insurance but to all corporate enterprises.[1] It does not appear that any such rigid enforcement of responsibility for truthfulness in reports was characteristic of American practice when publicity was tried as a regulator. Perhaps the precariousness of all enterprises in a pioneer country, the difficulty of establishing bad faith, and the general tendency to view charitably the mistakes of the honestly intentioned will explain this laxity. But it seems indisputable that strict accountability for untruth in reports is a *sine qua non*, if publicity is to protect.

In the second place, the difference in temperament of the two peoples must be considered. The British are traditionally conservative, patiently and painfully investigating before entering into a business transaction, and sticking to established connections in the presence of apparently tempting advantages in change. The winning of the new continent required the American to "take a chance." If he lost, he charged it up to experience and tried again. Time was too precious to waste in trying to understand the details of an intricate balance sheet, and it was too costly to employ an expert to do it for him. This era in American business is perhaps, with increasing integration, passing, but that it has not passed in personal practice is evidenced by the 1929 speculative inflation of market prices for stocks of enterprises whose managers had warned that the price was beyond the actual value. In the meantime the policy of state regulation and supervision has become so well established that a change in business practices would hardly cause its abandonment.

Insurance Not Subject to Exclusive Federal Control.—Before the systems of supervision of insurance by the several states had become as elaborate as they now have, and when the requirement of licenses was primarily for the purpose of state revenue, a case[2] arising out of refusal of an agent of a New York company to procure a license in Virginia was carried to the United States Supreme Court. It was contended that the requirement was

[1] TEN EYCK, ANDREW, "Some Precedents in British Law and Practice for Safeguarding Securities," *Harvard Business Review*, Vol. II, pp. 385*ff.*, especially 387.

[2] *Paul v. Virginia*, 8 Wall. 168.

in contravention of two clauses of the Federal Constitution, one giving the citizens of each state all the privileges and immunities of citizens in the several states, and the other protecting interstate commerce from state interference. It was held that corporations are not citizens within the meaning of the first clause, and that insurance is not commerce within the meaning of the second.

This doctrine was upheld in a number of other cases, the latest in 1913. In 1942 the South-Eastern Underwriters Association, a fire-insurance rate-making body, its member companies, and many individuals connected with it were indicted for violation of the Sherman Antitrust Act. The trial court sustained a demurrer based on the previous decisions of the Supreme Court, and the government carried the case to the Supreme Court. Two of the justices of the Supreme Court disqualified themselves. Of the remaining seven, four held the indictment valid and specifically held that insurance is commerce and that, when it crosses state lines, it is interstate commerce. Three justices dissented in vigorous language.[1] There was considerable criticism of the overthrow of a doctrine of such long standing by less than a majority of the entire court. The court, however, denied a rehearing. The government later quashed the criminal proceedings.

Leaders in Congress promptly denied that it was the intent of the federal government to overthrow the established system of state supervision but insisted that the states must actively supervise and not passively ignore intercompany agreements that might unfairly restrain competition. The insurance business was generally in favor of continuance of the state system of regulation. Early in 1945, Congress passed Public Law 15[2] which reads as follows:

> *Be it enacted, etc.*, That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the

[1] For the majority and dissenting opinions see *United States v. South-Eastern Underwriters Association, et al.*, 322 U. S. 533 (1944). For a discussion of the case and its effects see E. W. Sawyer, "Insurance as Interstate Commerce."

[2] Approved Mar. 9, 1945.

Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

Sec. 2. (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically relates to the business of insurance: Provided, That after January 1, 1948, the act of July 2, 1890, as amended, known as the Sherman Act, and the act of October 15, 1914, as amended, known as the Clayton Act, and the act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Sec. 3. (a) Until January 1, 1948, the act of July 2, 1890, as amended, known as the Sherman Act, and the act of October 15, 1914, as amended, known as the Clayton Act, and the act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the act of June 19, 1936, known as the Robinson-Patman Anti-discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Sec. 4. Nothing contained in this act shall be construed to affect in any manner the application to the business of insurance of the act of July 5, 1935, as amended, known as the National Labor Relations Act, or the act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the act of June 5, 1920, known as the Merchant Marine Act of 1920.

Sec. 5. As used in this act, the term State includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

Sec. 6. If any provision of this act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected.

Bills were introduced at the 1945 sessions of many state legislatures attempting to meet some of the conditions of this law. In most states the bills were rejected because they were not satisfactory to all interests involved. Committees of the National Association of Insurance Commissioners and of various groups of

insurance carriers are still working in the hope that such legislation as is imperative may be passed in all states before Jan. 1, 1948. In the meantime, because of the moratorium provided by section 3a of Public Law 15, state supervision remains practically as it was before the Supreme Court decision, though some state tax statutes and other laws that were thought to discriminate against carriers domiciled in other states have been amended or repealed. In October, 1945, the Supreme Court accepted an appeal from a criminal conviction in California in which the constitutionality of the statute of that state as to surplus line brokers is challenged on the basis of the S.E.U.A. decision. Further litigation may be expected.

Beginning of Separate Insurance Departments—Elizur Wright. The beginning of the modern type of supervision is usually associated with the appointment, in 1858, of Elizur Wright as one of the two insurance commissioners of Massachusetts. Prior to that time, Massachusetts had tried the ex officio board, and for 3 years a per diem board, but, in 1858, changed to two full-time salaried commissioners. New York, in the next year, established its separate insurance department, presided over by a superintendent, whose position is now the most important and influential in the field of insurance supervision, although the traditions and standards of the Massachusetts department give it very high standing.

Elizur Wright and Geo. W. Sargent were insurance commissioners of Massachusetts for 8 years, but Wright was the dominating personality. Their reports, especially those dealing with life insurance, may properly be called classics, not alone for their clear exposition of the important problems of the day and of the fundamentals of life insurance, but also for the vigor of their style and the firmness with which abuses were denounced and remedies proposed. Any student of life insurance or government supervision of corporate activity will be well repaid for the time spent in reading them.

Wright had succeeded in having passed, effective concurrently with the law establishing the department, a statute requiring life-insurance companies to report the particulars necessary for a determination of the reserve on a net-premium basis, and requiring the commissioners to calculate the reserve, allowing

them to determine the mortality table and rate of interest for this purpose. The application of this test showed one prominent British company to be insolvent. In the controversy that followed, the company employed eminent actuarial and mathematical talent in its defense. But Wright, with the support of the better American companies, exposed the fallacy of its position. From this beginning has developed the present requirement in all states of net-premium reserves (though with some modification to meet changed conditions in regard to expense) as a test of solvency for life-insurance companies.

Wright also secured the passage, in 1861, of the Massachusetts nonforfeiture law, which requires life-insurance companies to grant surrender values based on the policy's reserve in event of lapse, a requirement which has also become universal.[1]

Other contributions of this great reformer were the precedent of published reports containing the financial statements of the companies and illuminating comments on conditions in the business, and the example of a vigorous administration of the office of insurance commissioner.

National Association of Insurance Commissioners.—Following the precedents in New York and Massachusetts, separate insurance departments were established in several of the states during the next decade. With the institution of something more than merely formal supervision in these states, conference between commissioners became essential to prevent conflict in requirements and needless confusion. Cooperation became especially important as means of communication improved and companies extended their business over several states. In 1871, the National Convention (now Association) of Insurance Commissioners was formed, and it has met at least annually since that time. This is an extralegal conference composed of the insurance commissioners (or corresponding officials) of all states.

Although there is still great diversity in the insurance codes of the several states, the convention has done much in promoting uniformity in special laws[2] that have been recommended by it to

[1] See Chap. X.

[2] *E.g.*, the law providing for standard provisions in accident-and-health policies, and the uniform fraternal-insurance law.

deal with particular problems, and unity of action in examinations. Its greatest work has probably been in securing uniformity in the forms in which reports and financial statements are required.

Life Insurance Investigation of 1905–1906.—During the latter part of the nineteenth century certain of the large life-insurance companies, particularly those of New York City, were issuing *tontine* or *deferred-dividend* policies under which no dividends (refunds of excess of premium charged over the cost of insurance) were paid until after a certain time (usually 20 years) from the issue of the policy. The total fund, including the shares of those who had lapsed or died, and in the earlier forms including the reserves on the policies of those who lapsed,[1] was then to be divided among the survivors. This appealed to the gambling instinct, and the policies were sold as investments as much as, or more than, they were as insurance contracts.

No accounting being called for during the tontine period, huge sums were left in the hands of the companies, for which, for the time being, they were accountable to no one. This led to a race for size, the use of high-pressure sales methods, extravagant commissions, and frequent misrepresentation. Some of the weaker companies, trying to meet this competition without such huge funds, became involved and kept up a fictitious appearance of solvency by devious means. Some of the insurance commissioners were bribed, and others fended off in various ways. "Strike" bills against life insurance were introduced in legislatures, and bribery of legislators was concealed as legal fees. The officers of some of the companies participated in underwriting syndicates for floating securities, selling a large part of the securities to their companies and reaping substantial profits. In some companies, sinecure jobs were provided for relatives of officials, or lucrative agency contracts were given them.

A quarrel among the interests in control of one company attained such public notice as to bring on an investigation by a committee of the New York Legislature, under the chairmanship of Senator Armstrong, and with Charles E. Hughes as counsel. The abuses just noted were disclosed by that investigation. As a

[1] Special agreements were signed waiving the statutory nonforfeiture provisions until this was forbidden.

consequence, the regulation of life insurance in New York, and in many other states, was made much stricter, and the personnel of the insurance departments reorganized and strengthened.

Among the new requirements of life-insurance companies in New York was inclusion of the proceedings of each company's annual meeting in the annual report to the department. The names of all officers, and of others receiving more than $5,000, except in payment of a policy claim, during the year, the amount paid them, and the authority for it, were required to be reported. The basis of reserve was modified to meet modern conditions, and definite maximum limitations for expense of procuring new business were set. Deferred-dividend policies were forbidden, and standard policies were required. Restrictions on investments were tightened. A limit was set on the amount of surplus that might be accumulated. Some of the regulations were too drastic, for public opinion was much aroused, and some have been since modified,[1] but on the whole the results have been decidely beneficial. As bearing on the development of the present form of insurance supervision, the result to be noted is a considerable increase in statutory requirements and in administrative authority.

Investigation into Accident-and-health Insurance in 1910–1911.—In the course of an examination by the New York Insurance Department of a company conducting an accident-and-health-insurance business, largely among the poorer classes of working people, very reprehensible practices were discovered. The matter was so serious that it was taken up with the executive committee of the National Convention of Insurance Commissioners.

A committee of this Convention was accordingly appointed which made an investigation of fourteen or fifteen companies. Their time was limited, since they wished to report to this Convention, but the disclosures made by them were shocking in the extreme. Instead of basing the adjustment of claims upon equitable principles, some of the companies examined resorted to every form of trickery and deceit and even forgery and theft in order to escape their honest obligations. This was all the more outrageous in view of the fact that these frauds

[1] *E.g.*, the substitution of standard-provision requirements for standard forms.

were perpetrated upon the poorer classes who, in the very nature of things, should be given every possible protection.[1]

The action of the Convention, and of most of the individual commissioners, was vigorous, and the permanent result was the enactment in most states of a uniform law providing for standard provisions in personal-accident and health-insurance policy forms, and the prohibition of the use of any such form until it had been submitted to, and approved by, the insurance commissioner.

Fire Insurance Rates and the Merritt Committee Investigation of 1910–1911.—Prior to 1909, insurance commissioners had no power to regulate or to make rates. The theory in most states was that competition was the proper regulator of prices and that free and open competition should be allowed, and even forced, to function. Three types of laws are indicated by this theory as necessary and desirable:

1. A law against combinations for control of rates, known as an *anticompact* law.
2. A law forbidding unfair discrimination in rates, known as an *antidiscrimination* law.
3. A law forbidding division of an agent's commission with the insured, or giving the latter any other special consideration or gift, known as an *antirebate* law.

Laws of each type have been enacted in nearly all the states and still appear on the books of some, but those of the first type are gradually being displaced by laws providing for positive regulation, as it has come to be realized that combination of experience is necessary to sound rate making. Kansas, in 1909, passed a law requiring the filing of fire-insurance rates with the Superintendent of Insurance, and giving him a veto power on rates as filed. The constitutionality of this statute was tested in the United States Supreme Court, in connection with his first act under that law, and was sustained.[2] Several states have followed this lead, Texas going so far as to vest in a board, of which the Insurance Commissioner is an ex officio member, the actual making of rates for fire insurance.

[1] From presidential addresses of F. W. Potter, Superintendent of Insurance of Illinois, opening 42nd Session, National Convention of Insurance Commissioners, at Milwaukee, Wis., Aug. 22, 1911. *Proceedings of the National Convention of Insurance Commissioners*, 1911, Vol. I, p. 14.

[2] *German Alliance v. Lewis*, 233 U. S. 389 (1914).

Criticism of fire-insurance rates in New York led, in 1910, to the appointment of a legislative investigating committee under the chairmanship of Senator Merritt. Their report contained an excellent discussion of the problem of fire-insurance rates, including the problems of fire prevention as affected by insurance rates, and of the relation to rates of the ratio of insurance to value and the coinsurance principle. Their recommendations, as embodied in the New York law, have become a precedent for several states. Under this system, a carrier is permitted to belong to or subscribe to a rating organization for every district in which it operates in the state, and to adhere to its rates, or to file its own rates and adhere to them. The Superintendent supervises these organizations to prevent unfair rates and must examine them periodically.

Workmen's Compensation and Other Casualty Lines and Limitation of Expense.—When the New York workmen's compensation law was under consideration, and a strong effort was being made to make the insurance under it a state monoply, the then Superintendent of Insurance, Hon. W. Temple Emmett, realizing that, if private insurance carriers were to be allowed to write this insurance at all, they must keep expenses within a much narrower margin than was the practice for employers' liability insurance, called a conference of company executives and secured a general agreement to restrict acquisition cost to 17½ per cent of the gross premiums, with modifications for states where conditions appeared to require higher expense.

When the Massachusetts workmen's compensation law became effective, a concurrent law required that rates be approved for adequacy[1] by the Insurance Commissioner. The then Commissioner, Hon. Frank H. Hardison, took the position that the rate could not be approved as adequate unless there was assurance that expense, which is in the control of the carriers, be kept within the margin provided for it. Acquisition expense is the one most likely to be driven beyond bounds by competition, and the commissioner required a signed agreement from each carrier that such expense would be kept within a limit at 17½ per cent and required a special supporting report at the end of the year.

[1] The interest of the workers demands extra precautions against insolvency.

This precedent has been generally followed where workmen's compensation-insurance rates are subject to the approval of the insurance commissioner.

After some experimenting with the approval of special rates for concerns whose plants were in unusually safe condition as certified by his inspector, the Massachusetts Commissioner approved general plans of schedule and experience rating, provided the companies formed an administrative bureau for their nondiscriminatory application. This precedent has also been followed in several states. Membership in bureaus subject to departmental supervision and control is required. The bureaus compute from data supplied by the carriers the proper experience modification for each risk and promulgate the classifications and rates under which it is to be written. The carriers are required to send to the bureau copies of daily reports, which are then checked for accuracy of classification and rate.

In 1921 the New York Legislature appointed a committee under the chairmanship of Senator Lockwood to investigate the reasons for the shortage of housing in New York City, and to propose remedies therefor. It was argued before that committee that unfair and excessive rates for surety bonds and liability insurance on building construction and apartment-house operation unduly increased the cost of providing housing facilities. The committee recommended that the Superintendent of Insurance be given similar supervision over rates for practically all forms of casualty insurance as he then had over workmen's compensation insurance. Such legislation was passed in 1922. This precedent has not been followed in other states. Supervision of these rates is a most difficult task, because it involves regulation of expense as the major problem. The expense problem is intimately associated with agency-organization plans and nationwide competition. Since not all carriers do business in New York, some of those which are entered in that state meet in competition, outside of New York, companies over which the New York Superintendent has no jurisdiction. As the other commissioners have no jurisdiction over the problem, it would be difficult, if not impossible, to force such companies to conform to rules developed for companies operating in New York, and they would have a competitive advantage in the acquisition of business.

Necessary Regulation.—After reviewing in this necessarily brief way the development of state supervision and regulation, it is pertinent to consider how far such regulation is necessary.

In the present state of affairs, with the precedent of supervision of banks and other financial institutions, it requires little or no argument to reach the conclusion that most persons would consider the supervision of investments and finances, with a view to assuring solvency, highly necessary. Even the best supervision has not prevented all failures or frauds, and it has probably led to a false sense of security in some cases, but on the whole it has served well. The first reason for supervision, the complexity of modern economic life, seems to be determinative on this point.

It will probably also be generally conceded that regulation of policy forms is equally necessary. This is closely analogous in principle to our modern pure-food laws. The highest ethical standards demand fair contracts as they do pure foods. But both cost more than the spurious or adulterated article, and the latter may therefore be sold at a lower price. With something that we can inspect before we buy, as clothing or automobiles, the rule of *caveat emptor* may still apply. But when it takes a legal training or a chemical analysis to determine the false from the true, we need state supervision to safeguard true thrift.

Fair treatment and the absence of unfair discrimination also may well need to be assured to all and, if it takes state supervision, as apparently it does, to give that assurance, the necessity of such supervision and regulation may be conceded.

Since access of the public to insurance carriers is almost exclusively through agents and brokers, it also appears desirable and probably necessary that there should be regulations to prevent incompetent and untrustworthy persons from acting in such capacity. The public may also be victimized if incompetent or untrustworthy persons are permitted to act as public adjusters. Most states now require that candidates for licenses to act in these capacities give evidence, usually by passing examinations, of competence and have no evidence of dishonest action in the past upon their records. The standards of required competence have been steadily rising during the past decade.

As to other matters the necessity is not apparent. Excessive

expense is a relative term and, although economical administration of the insurance business is desirable, it is not so necessary that it alone would justify state intervention. The same may be said of rates.

Desirable Regulation.—Is regulation of rates and expenses desirable?

As to expense, the answer would appear to be affirmative, at least as to the setting of maximum limits. It has already been pointed out that, as in many other industries, competition tends to increase selling costs, rather than to bring lower prices. Expenses may so trench upon income as to endanger solvency, and excessive commission allowances tend to encourage secret rebating and other unfair practices.

In favor of rate regulation are

1. The practical assurance of fair and equitable treatment to all in the matter of cost; and apparently

2. The assurance of a scale of rates that, with a fair selection of risks and reasonably economical administration of expenses, will go far to assure the solvency of carriers.

Against it are

1. The fact that, provided the expense is kept within the maximum limit, there is no competitive advantage to the joint-stock carrier which is successful in bringing its expense below the average. It is unfairly handicapped in competition with a mutual insurance carrier in which expense has been kept low, since that low expense may be reflected in its dividend rate.

2. The tendency to rigidity in forms and rate structure, particularly of classification systems and rating schedules, under bureaucratic domination.[1] This checks flexibility to meet changing conditions.

3. The probability of decisions being based on considerations of political expediency rather than equity.

4. The general arbitrariness of bureaucratic administrators with pride of power.

State vs. Federal Regulation.—Since the decision of the United States Supreme Court holding that insurance is commerce, with

[1] This tendency has been manifest also in carrier-controlled bureaus and has been the reason for revolt from time to time of strong carriers with executives of aggressive personality.

the implied threat of federal regulation replacing that of the states and the attempts of states that have not heretofore exercised rate control to pass legislation providing for it, these points have been much emphasized. The consensus in the business seems to favor state (local) regulation rather than federal on the grounds that,

1. Conditions affecting risks in all fields vary widely from section to section.
2. Local authorities are familiar with local conditions and will recognize their importance more readily than the more remote federal authority in Washington. Thus local regulation will bring about greater equity than will central regulation.
3. The federal bureaucracy under civil-service tenure tends to be more rigid and arbitrary than does that of the states, while such uniformity as is desirable can be obtained through the conferences of the local authorities in the National Association of Insurance Commissioners.
4. Pressure groups can maintain more effective lobbies in a single center at Washington than they can in each of the several states.
5. Supervision of rating bureaus is preferable to direct governmental rate making.

It is urged, however, in favor of federal regulation that

1. Notwithstanding Public Law 15 there remain certain aspects of the insurance business which are now regulated by federal statute,[1] and certain aspects as to which there is doubt whether the state police power or federal regulations apply. If there were exclusive federal regulation, the uncertainty as to overlap would not exist.
2. If there were exclusive federal regulation, there would be much less burden on the carriers by way of reports and other duties in complying with state laws.
3. Conflicts in rulings on the same subject matter[2] would be less likely to arise.
4. Examination procedure would be simplified and more uniform, though much has been accomplished toward that end by the

[1] *E.g.*, relations with employees are subject to the Labor Relations Act.

[2] *E.g.*, the approval of policy forms.

zone system of examination under the supervision of the National Association of Insurance Commissioners.

5. Certain aspects of rate making are national in scope.[1]

6. Many insureds have locations and operations in several states and desire coverage of them in single policies and merit rates, based on their combined risks. This is difficult to accomplish under state regulation.

7. It is desirable that there be considerable flexibility in insurance forms and practices to meet the needs of business under changing economic conditions. The system of state regulation, requiring in some cases the approval of more than one state authority, imposes considerable rigidity that some feel would be less under federal control.

The regulation of insurance investments by the states has been on the negative side, that is, there has been prohibition of investment in securities not deemed eminently safe, but no compulsion that investments be diverted to uses approved by the state policy. During the T.N.E.C. hearings there was considerable emphasis on the proposition that the country needed more venture capital, especially for the benefit of small business. It was intimated that the huge accumulations of the insurance business, particularly the life-insurance business, and the conservatism of its investment policies tended to restrict the amount of venture capital. It seems to the writer that this has led some conservative insurance executives to fear federal regulation, lest theorists coming into federal bureaus in a liberal administration might attempt to improve the opportunities of small business by compelling insurance investments to flow into channels which these executives felt unsuited for trustee funds. Of course, Congressional action would be necessary. But they would have to oppose before Congress the recommendations of the government bureau and might easily be placed in an embarrassing position.

SUMMARY

1. The business of insurance in the United States is naturally subject to much governmental regulation.

[1] *E.g.*, the risk of conflagration losses in fire insurance should be spread nationwide.

2. Marine insurance as conducted in medieval Europe was subject to extensive governmental regulation, which looked to the forms of contracts to rates and practices, rather than to solvency of the underwriters.

3. Early British insurance, being conducted largely by resident foreigners, was regulated by trade customs and agreements, and in consequence there was practically no governmental regulation. There was also practically no governmental regulation of insurance in the American colonies.

4. The earliest regulation of insurance in the United States was through the charters of the companies granted by special statutes.

5. The securing of licenses and the filing of reports were first required as a basis for taxation.

6. General incorporation laws provided for some regulation of investments and for the filing of certain reports.

7. As abuses occurred in the practice of insurance, extension of regulation to prevent them was a natural consequence.

8. The more common types of abuses have been

a. Use of improper policy forms.
b. Failure to live up to contracts.
c. Unfair discrimination.
d. Failure to make adequate financial provision for meeting losses.
e. Unwise and speculative investments, and graft.

9. Publicity alone has not proved a sufficient safeguard in the United States, though more effective in Great Britain. Differences in temperament and other conditions account for this situation.

10. Insurance is subject to control by the federal government, but the separate states still exercise control, since the federal government has exercised its powers only in a limited way.

11. The National Convention of Insurance Commissioners has been evolved as a means of achieving more or less uniformity in the administration of the insurance laws of the several states.

12. Regulation to assure solvency, proper forms, and fair treatment of policyholders is probably necessary.

13. Regulation to curb expense is probably desirable.

14. The desirability of direct rate regulation is open to debate. Indirect rate regulation, through regulation of cooperative rate-making bodies and publicity of methods, is open to less serious objections and has much to commend it.

15. There is still disagreement as to the respective merits of state and federal control as a long-range policy and as to how, if at all, major control may be maintained in the states.

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CHAPTER XXVIII

METHODS OF STATE SUPERVISION

In Chap. XXVII the development of state supervision of insurance, from the few and desultory regulations in corporate charters granted by special acts to the complex and detailed practice of today, was briefly traced. In that account the establishment of the state insurance department as a separate agency was noted. The manner in which that department operates will next be discussed.

Insurance Department.—The head of the department, whether called insurance commissioner, superintendent of insurance, or by some other title, is usually appointed by the governor for a term not exceeding 4 years. Sometimes he is elected, and in a few states the office is still a division of that of the auditor or treasurer. In the more modern forms of state government on the cabinet model, the department is a bureau of the department of finance or of corporations. Although some commissioners have been reappointed and have served several terms, many have died or resigned before the expiration of the first term. Usually the appointee has had no previous insurance experience, the law generally providing that, during his term of office, he shall not have an interest in any company other than as a policyholder. Consequently he can usually do little more than take general executive charge. The staff of the department, however, is usually more permanent, and in the larger departments, such as that of New York, contains well-qualified experts whose recommendations usually govern the policy of the commissioner.

Incorporation of Companies.—In nearly all states insurance companies may be organized in accordance with general statutory provisions. Sometimes the articles of incorporation, after being filed with the insurance department, become the charter when approval is given by the department and other formalities have been completed. In other cases the granting of the corporate charter is a matter for the secretary of state or the corporation

department, and the insurance department does not get jurisdiction until the organization is completed and the company is about to do business. Then it must procure a *certificate of authority* from the insurance commissioner. Before this certificate is granted, he usually must satisfy himself that the charter papers are correct, that the kinds of business the corporation proposes to do are within its corporate powers and the statutory limitations, and that it has the required minimum capital invested as prescribed by law. This he does by sending an attaché of his office, known as an "examiner," to the company's office, to examine its books and records and to verify the possession of the assets claimed by actual count of securities, cash, and certificates of deposit. Sometimes it is also incumbent upon the commissioner to investigate the organization expense, and the certificate may not be issued if the expense has exceeded a certain proportion of the capital. This is reasonable, for experience has shown that excessive organization expense often places such a handicap on a company that its future success is highly problematical.

As previously noted, a reciprocal exchange is not a corporation. It has, however, articles of association and by-laws, and it must file these with the insurance commissioner as well as a copy of the power of attorney which the subscribers are required to sign when applying for insurance. These take the place of the charter of a corporate insurer. The attorney in fact must give a surety bond to protect subscribers, usually of $50,000, and a copy of this must also be filed.

In the case of a company of another state (a *foreign* company), a certificate of authority is also necessary to transact business legally in the state, and its granting is contingent on the same showing. Usually, however, the examination will be made by the home state's department, from which it must have previously secured its certificate of authority. Usually, also, some local person must be designated by a foreign company as attorney for service of process should an action be instituted in the state.

Alien Corporations.—In all, or nearly all, states an *alien corporation* (a corporation organized under a charter from another nation) may not be admitted until it establishes a United States branch in one of the states. If it does so and if the branch seeks

admission to do business in another state, it is treated as a foreign company domiciled in the state in which it is established. The alien company must appoint a United States Attorney (not necessarily an attorney at law) who is legally its responsible representative in the United States, authorized to accept service of legal process and responsible for its relations with the supervisory authorities. He may or may not be the principal business manager of its United States branch. It must also appoint a United States trustee (perhaps a trust company) or set of trustees who are responsible for the care of the United States assets. It must maintain at all times, in the custody of its United States trustees, assets in excess of its United States liabilities[1] by not less than the amount of capital required of a domestic company to do the same kind of business. The deed of trust must dedicate United States assets exclusively to the protection of contracts issued here. If the company fails to maintain its United States assets at the required amount, the branch is regarded as insolvent and may be treated in the same manner as an insolvent domestic company. Profits and surplus funds of the United States branch may be remitted to the home office subject, in some states, to the approval of the state insurance commissioners. The investments of the branch must conform to the laws governing investments of domestic companies. In practice, a United States branch of an alien company becomes effectively a domestic company.

Powers of Carriers.—State laws set up in detail classifications of kinds of insurance, defining the scope of each class[2] and specifying the minimum capital required of a stock corporation to permit it to do each class. The laws also specify which classes may be done by the same corporation and the capital required for the various permitted combinations. The laws of some states are so broad that a single corporation may do all classes except

[1] Usually only those arising out of contracts issued in the United States. It may have liabilities in the United States under policies issued elsewhere, *e.g.*, life-insurance policies whose holders have migrated to the United States. With the free migration permitted across the Canadian border it would be practically a hopeless task for a Canadian company to keep track of such liabilities and transfer the records to the United States branch, especially as the visit across the border may be temporary and not reported to the company.

[2] The Insurance Code of California, for example, sets up 20 classes.

life insurance. The tendency now is to broaden the underwriting powers of carriers, so that eventually one carrier may be permitted to cover broadly all an insured's insurance needs except life insurance. A carrier doing a life-insurance business may usually also write accident and health insurance and sometimes liability and workmen's compensation insurance but rarely any other lines. It is generally felt that the nature of life insurance with its large investments and long-term contracts makes it unwise to expose its assets to the risks of other kinds of insurance. Abroad, where underwriting powers are generally more liberal than here, if a company writes life and other kinds of insurance, the life-insurance funds must be kept separate from funds pertaining to its other business. The charter of a corporation usually specifies the kind of insurance that it may write. The various combinations fall into four categories.[1] Mainly because of these limitations on underwriting powers but also for other business reasons, it is now common for *fleets* of companies to be operated under common management or common ownership. Sometimes a fire-insurance company will own all[2] the capital stock of a casualty company, or vice versa. For various reasons, a company may not be authorized in some states to do all the classes of business permitted by its charter. Some companies may elect not to exercise all their charter powers for a considerable time, building up a business in certain lines before embarking in others.[3]

The requirements of state laws for the qualification of domestic mutual companies vary among the states and by type of insurance. The limitation of powers as to kinds of insurance is much the same as for stock companies. This is true also as to reciprocal exchanges. If a foreign mutual applies for admission, the law usually requires that it have a surplus over all liabilities at least

[1] See pp. 139 and 140.

[2] Except directors' qualifying shares in states where the laws require directors to be stockholders.

[3] Some old charters, granted by special legislation before general incorporation laws were enacted, permit the corporation to write life insurance as well as fire or marine, for both of which they cannot anywhere be licensed. Such companies have issued some life-insurance policies in the past, but these have now expired and the companies do not exercise their power in this field.

equal to the capital requirement for a stock company to do the same kind of business.

Agents' and Brokers' Licenses.—After a company has procured its certificate, it must see that all who represent it as agents in the transaction of its business are duly licensed. This is usually merely a formality, but in some states there are *agents' qualifications laws,* under which the insurance department must inquire into the qualifications of proposed agents. Suspension or revocation, and absolute denial of future license, are penalties for certain types of misconduct by agents. Usually the extreme penalty is only to be invoked for such fraud or embezzlement as would constitute a crime.

The broker also must secure a license each year. Since he is a free lance, no company procures his license, and he is held to stricter qualifications.

Until well within the last 20 years the requirements of agents' and brokers' qualification laws were rather easily met. Generally the commissioner was merely required to satisfy himself, upon the evidence presented and recorded as to the integrity of the applicant, that he was of good reputation, had had experience or instruction or within 30 days would be given instruction in the kinds of insurance he proposed to write, had not been denied a license or had a license revoked; and that he was not applying for a license merely to get a rebate, under the guise of a commission, on his own insurance or on insurance on property he controls.

Recently the tendency has been to require more positive evidence of real qualification. The following sections of the Insurance Code of California are typical of this new movement:

1661. Each applicant for a license to act as an insurance agent, broker, or solicitor, who, at the time of the application, has not within two years previous to date of application, held a license to act in any one of those three capacities, shall take and pass a qualifying examination provided by this article.

1674. The commissioner shall conduct or arrange for a written examination, to be given at least twice a year upon questions, prepared by the commissioner, as to the qualifications of applicants or members or officers of applicants to act as insurance agent, broker or solicitor.

1675. The examinations shall be of sufficient scope to satisfy the commissioner that the applicants have sufficient knowledge of, and are

reasonably familiar with, the insurance laws of the State and with the provisions, terms, and conditions of the insurance that they propose to transact, and have a general and fair understanding of the obligations and duties of an insurance agent, broker, or solicitor.

1676. A license shall not be issued under this article to any person required to pass an examination, until such examination has been passed, but the commissioner may issue to an applicant a certificate of convenience, operative for a period not extending beyond six months from issuance nor beyond the first day of July next succeeding issuance, permitting such applicant to act as agent, broker, or solicitor, as the case may be, pending a fulfillment of the examination requirements.

1677. Failure by an applicant to take the examination within thirty days after notification by the commissioner of readiness to hold the examination constitutes a failure to fulfill the examination requirements. Upon such failure by the holder, all privileges under any certificates of convenience shall terminate. In such case return of the application fee shall not be made.

Penalties for Acting without License or Representing Unauthorized Companies.—In nearly all states there are severe penalties provided for acting as an agent or broker without a license. The fines are substantial, and there is frequently an alternative of imprisonment at the option of the presiding judge. Usually a single offense is sufficient to invoke the penalty. In brief, the law makes it unprofitable to act as an insurance agent without a license. Licensed agents through their organizations keep tab on the licensees, and anyone operating without a license is likely to be promptly reported. Consequently it is not often done. These conditions make the revocation of license a severe penalty for misconduct, since it drives the offender out of business.

Although there are provisions under which a broker, who has complied with certain requirements, may place with unauthorized insurance carriers lines that he is unable to place with those authorized, the penalty for representing or placing business with an unauthorized carrier is as severe as for operating without a license. It might be difficult to reach and impose any penalty on a carrier of another state, which defied the local law, but any person representing it within the state may be arrested. Residents may be more readily reached, and penalties more surely imposed.

These penal provisions reaching to the individuals give real

force and sanction to insurance regulatory laws, and real power to commissioners.

Revocation of Licenses.—From what has just been said, it will be apparent that the power to compel obedience to regulation rests in the power of refusal, or revocation, of licenses and certificates of authority. This power is not often exercised. The right to exercise it is usually sufficient to prevent the need. In some states the commissioner may refuse or revoke "for good cause shown," though his action is subject to court review. In such cases, if it is shown that the commissioner has exercised a reasonable discretion for the protection of the public, the courts will usually not interfere.

As to agents and brokers, the law frequently provides that a license is not to be granted, if the purpose of the applicant is mainly to obtain the commissions on policies issued to cover his own risks or those of properties he controls. This would be tantamount to a rebate or preferential rate. Revocation is ordinarily only possible for essentially fraudulent transactions, embezzlement of premiums from either the insured or the company, or misrepresentation of policies, or *twisting*, the inducement by misrepresentation to drop one policy in order to take out another in a different company, a transaction more frequent in life insurance than in any other branch and one which almost always results in loss to the insured.

Refusal of license to a company is always in order if the company cannot meet the standards set up in the statute for admission to do the kind of business for which the license is desired, that is, if the power to do so is not granted under its charter or it has not the legal minimum capital. Sometimes the commissioner may go further and deny the license if he believes the company will not be able to operate safely.

Revocation of license is prescribed for violation of some of the statutory requirements and is also in order in cases of evident insolvency. In most states persistent willful fraud will also justify revocation. In some states, *e.g.*, California, the commissioner may suspend the license for 1 year, if he ascertains that the company is conducting its business fraudulently, is not carrying out its contracts in good faith, or habitually forces

the insured to accept less than is due in order to avoid litigation.[1] There is considerable variation in detail in the several states. In some the commissioner has more discretion than in others. But a resourceful, vigorous commissioner can usually find the power to enforce sound practice and good financial condition.

General Enforcement of Law.—The insurance commissioner is charged with the general enforcement of the insurance law, not, however, in the sense that the sheriff is so charged. For he has no power to arrest and hold, although in some states, in cases of probable insolvency, where delay may cause irreparable loss, he may seize the assets and books of a company before petitioning the court for appointment as conservator. Having taken possession, however, he must obtain sanction of the court.[2] Nor is his power like that of the district attorney, who personally conducts the prosecution of the offender. But he has broad inquisitorial powers and usually is required to report his findings of violation to the district attorney, or to the attorney general, who then must act to bring the offender to trial.

Assuring Financial Solvency.—The most important function of the insurance department is that of assuring, as far as possible, the financial solvency of carriers, and particular powers are granted in nearly all states for this purpose. These powers fall into two closely related groups: (1), the requirement of reports and (2), examination.

Reports.—All companies are required to make annual reports of their transactions for the calendar year, and of their financial condition as of Dec. 31. Sometimes the statute prescribes the form of this report in detail, but the commissioner is usually authorized to modify the statutory form. In practice, use is generally made of the uniform blank prepared by the Committee on Blanks of the National Association of Insurance Commis-

[1] Sec. 704 Insurance Code.

[2] See Insurance Code of California, Secs. 1010 to 1012. Sec. 63 of the New York Insurance Law is similar in intent. It authorizes the court, upon application of the Superintendent setting forth certain grounds, to enjoin (without a hearing) the transaction of business. On return of the order to show cause, the Superintendent may be authorized to take possession of the property and liquidate the business. It is intended that the proceedings be brief and summary to permit prompt action in emergencies, such as looting by officers.

sioners. If these blanks do not call for all the information required, the commissioner requires supplementary reports.

These reports show the income and disbursements of the year analyzed in great detail by sources, and the assets and liabilities summarized by kinds. They are supported by elaborate schedules showing the details of investments at the end of the year, and the changes in them during the year. Schedule D, which exhibits the stock and bond holdings, is a typical schedule, and will serve as an example. It is divided into four parts. Part 1 includes, for each block of bonds owned at the end of the year, a description, the interest rate and payment dates, maturity and options, par value, value at which carried on the books, cost, market value (sometimes the amortized value may be substituted), interest received during the year, and amount of interest due or accrued at the end of the year, as well as the adjustment, if any, which was made during the year in the value at which it was carried on the books. If amortized values are used, other particulars are shown which permit a check of the determination of that value. Part 2 includes, as to each block of stock owned, a description, the par value, value at which it is entered on the books, cost price, market value, dividends received during the year, the dividend rate for the last 3 years, year acquired, and any adjustments made in the value at which it is entered on the books. Part 3 includes, as to each block of bonds or stocks acquired during the year, a description, date acquired, from whom acquired, cost, par value, and the amount paid for accrued interest. Part 4 includes, as to each block of stocks or bonds sold, redeemed or otherwise disposed of during the year, the description, date sold, name of purchaser, consideration excluding accrued interest, par value, cost to company excluding accrued interest, value carried on books at date of sale, any adjustment in that value made since the last report, the profit or loss on sale, and the interest or dividends received during the year, including the amount received for accrued interest when sold.

These asset schedules show completely the details of the investments in hand and, as is evident, much more data which will immediately disclose when a company has been speculating with, rather than investing, its funds, as well as when an inside

ring has been accorded improper profits by selling investments to the company, or by buying them from it. The other asset schedules are similar in form. Where the liabilities can only be estimated, as with claims in process of adjustment, there are frequently schedules exhibiting the actual payments during the year, and a new estimate of liability compared with the estimate of a year ago on the same claims, thus showing up any substantial inaccuracy.

There are other schedules of resisted and scaled-down claims, and of salvages, which give further light on the liability side of the balance sheet, as well as upon the practices of the company in treatment of claimants.

The blank also calls for a gain-and-loss (or underwriting and investment) exhibit, tracing the increase or decrease in the company's surplus during the year to its sources in underwriting profit or loss, investment return, dividends to stockholders or policyholders, etc.

These schedules and the supplementary data give fairly satisfactory material for an audit of the statement and, if it is made with care, much skill will have to be exhibited by the company officials to make a false showing that would not disclose itself on such an audit.

These statements are intended to be carefully audited by the insurance commissioner's office, but in comparatively few states is the department sufficiently manned to audit properly all of the statements filed with it. An audit is usually made of the statements of *domestic* (home-state) companies and of those about which suspicion has been aroused. All statements are, however, filed as public documents open to general inspection and are scrutinized by representatives of competing companies, who do not hesitate to tell of any weakness they find. The commissioner's office frequently gets valuable hints in this way.

The commissioner is required to submit an annual report, which includes condensed summaries of the statements filed. Questions raised by the public after review of these published reports will rarely, however, bring a bad situation to attention in time to save it. The information in these reports should help the public to discriminate somewhat between the strong and weak.

Investments.—In some states the companies are required to report investments made more frequently than once a year, and the commissioner is authorized to veto any investment and require it to be sold if it is not within the law.[1]

Examinations.—Although these statements and reports must be made under oath of the companies' officials and contain internal checks, perjury and skillful manipulation of accounts are not beyond the limits of human weakness and ingenuity. Defects of this sort can be caught only by examination of the accounts and records of the company; sometimes examination of witnesses under oath is required. The commissioner has such power of examination and may employ expert assistants to whom he delegates the power. He may make an examination as often as he deems necessary, though he may not use the power arbitrarily or oppressively. Revocation of license, with the possibility of application for a receiver, may be the penalty for refusal to submit to it. In most states, the commissioner is required to examine domestic companies at intervals, usually not less often than once in 3 years.

The examination must be private, and usually the commissioner is not authorized to give out the results until the report has been submitted to the company, and an opportunity given to object to statements and conclusions. However, in emergency cases, for the protection of the public he may often act at once, as under the California liquidation provision cited above. California also authorizes publication, if the commissioner deems it necessary, and prescribes the form.[2] The carrier has, of course, the right of appeal to the courts if it feels aggrieved, and the commissioner, who is under bond, acts rashly at his own peril.

Independently of revocation or suspension of license, the power of examination and of publicity is a strong deterrent weapon in the hands of an able commissioner dealing with persons who would prey upon the public through the guise of an insurance enterprise. It has many times been effectively used, though sometimes manipulators have escaped their just deserts.

[1] Section 1202, Insurance Code of California.

[2] New York Insurance Law, Section 39; California Insurance Code, Sec. 735.

Insolvency—Conservatorship—Rehabilitation.—Usually in the liquidation of an insurance carrier there is a very great loss of intangible but real values, *e.g.*, the agency organization built up at much effort and cost is dissipated. Creditors may fare much better if arrangements can be made to conserve and rehabilitate the carrier. This was demonstrated in several cases during the depression of the thirties. Some states have made definite provision for *rehabilitation* in their statutes. The insurance commissioner is authorized to proceed directly[1] to the court in whose jurisdiction a carrier is domiciled when he finds, after an examination, that a carrier is insolvent[2] or in such a condition that further transaction of business would be hazardous to its policyholders, or creditors, or to the public, or that its officers have committed certain acts defined in the statute. He may so report and apply for an order appointing him *conservator* or the equivalent. This appointment vests in him and in his successors in office title to all the carrier's assets and empowers him to carry on all or a part of the business. The court must grant the order which stays in effect until, on application of the commissioner or the carrier, after full hearing, the court finds that the grounds for issuing the order did not exist or have been removed and that the carrier may properly be permitted to resume title to its property and conduct of its business.[3]

If at any time, the commissioner concludes that it is futile to try to rehabilitate the carrier, he may ask that the conservatorship be dissolved and that he be appointed liquidator. If this is done he takes the carrier over for liquidation.[4]

The purposes of the conservatorship are

1. To check destructive forces, perhaps by abandoning some parts of the business or by cutting off expensive arrangements, which the management was unable or unwilling to do.

2. To compromise, if possible, with certain creditors or arrange to defer their claims.

[1] Not as in criminal matters reporting the facts to the prosecuting officers for action in their discretion.

[2] The statutory definition of insolvency in several, if not most, states includes, as one of several possible conditions, impairment of capital beyond a fixed per cent, in California, for example, 25 per cent.

[3] See Insurance Code of California, Secs. 1010 and 1062.

[4] See p. 532.

3. To arrange new financing, or

4. To create a new corporation of similar name in which to reinsure satisfactory business and carry on until suitable arrangements for the other business can be made when the business may be reinsured again and the new corporation dissolved, or

5. To develop some other suitable plan of rehabilitation.

In the case of at least two large companies which got into such difficulties in the thirties that they might otherwise have been forced into liquidation, these procedures were successfully used, and creditors who compromised or deferred their claims fared much better than they would have done had the companies been liquidated.

Supervision of the Treatment of the Public.—In some states the insurance commissioner is made the agent through whom interested parties may seek information regarding a particular insurance policy which they find difficulty in obtaining otherwise. For example, under Secs. 12950 to 12955 of the Insurance Code of California, on receipt of an affidavit showing that the maker is entitled to the benefits of the section and on application for a certificate of the facts from the commissioner, he must in turn apply to the company and transmit its answer to the applicant.

In nearly all states complaints against companies may be taken before the department. Revocation of license or insolvency proceedings are not generally in order, unless the mistreatment of claimants is habitual and intentional, but a public statement reprimanding a carrier for its treatment of claimants is most effective. The carrier has its remedy against arbitrary action in a suit for libel, but to win it must be clearly in the right and, if there is a doubt as to its good faith, it gets further undesired advertising through such a suit itself. Theoretically, the courts are the means to which the claimants should resort to enforce their rights. Practically, such action is often impossible because of the cost. The commissioners may often put such pressure on unfair company claim men as to compel at least a compromise. The insurance department is in no sense a legal-aid bureau, although many state insurance departments maintain *complaint bureaus* and sometimes, when the company's side is heard and the claimant is confronted with it, his own record convinces him that he has come to the wrong place, and as prompt a disappearance as

possible takes place. The attachés of the office handling complaints are called upon for the greatest amount of tact and understanding of human nature, as well as firmness in dealing with both sides. The greatest amount of this kind of work arises in connection with the limited types of personal health and accident policies.

Rate Supervision.—It has been pointed out that the states have continually extended their jurisdiction over the rates charged for insurance. In some states where there is close supervision, or actual rate making by the state,[1] this work is delegated to a board or commission of which the insurance commissioner may or may not be a member. In others, the entire work centers in his office. In others, again, the insurance commissioner may have exclusive jurisdiction over rates for one or more classes of insurance, jurisdiction over other classes being delegated to another body.

Where the supervision of rates rests in the insurance department, it is usually exercised in one or more separate bureaus of the department. The department's supervision may be in any one of three forms, of which the simplest is the maintenance of open files of rates as filed by the companies, without power to approve, disapprove, or modify. The department is then merely an information bureau as to such rates, though usually the laws forbid rebates and other unequal application of the rates, and if, through inquiries regarding rates, violation of these laws is shown, the commissioner must invoke the penalties of the laws.

The next step in supervision, and the latest to be developed, is the supervision of rate-making bodies. Practice of such supervision varies greatly but, under the best practice, full details of all formulas and methods, and changes in them, are filed with the commissioner. His representative scrutinizes rates and methods to ascertain whether they are likely to cause unfair discrimination between individual risks and classes of risks or to result in inadequate or excessive rate levels. If such results are found to be inherent, the matter is taken up with the rating bureau, and it is required to modify the method. If the bureau objects, it may have a hearing before the commissioner who may modify his

[1] *E.g.*, Texas and Oklahoma.

ruling if he is satisfied that it was in error. His representative may attend committee meetings, though usually such attendance will be as an observer to ascertain more of the basis for proposed action than is shown in the written record. Individual files are examined from time to time, and a full examination is made at least triennially. This examination does not, like that of a company, deal primarily with finances and accounts, since the financial condition of the organization is of no great moment. It deals rather with the practices in the collection and use of data for rate making, and the results attained. The reports of these examinations are published and, since any criticism of unfair practices would undoubtedly bring adverse legislation, this threat serves to hold in check any tendency to take unfair advantage. A large part of this kind of supervision is concerned with complaints that are made to the department from time to time regarding individual rates or classes of rates. In these cases the department sees that the complainant is advised by the bureau of the make-up of his rates or rate. If the bureau has made an error, it will usually correct it without further action by the department. If the rate was not due to an error in the application of regular methods and the complainant is not satisfied with the bureau explanation, the department then must review its consideration of the method and, if it is found not to operate fairly, to require modification. If the department finds no merit in the complaint, it will so advise the complainant. The author knows of no appeal having been taken to the courts in such a case.

Approval or disapproval of rates, to be intelligent, must be based on statistical data, and underwriting and other evidence for the gathering of which few state insurance departments are adequately equipped, in either machinery or personnel. In practice, therefore, the companies are required to stand the expense through a rating bureau. The technique of supervision is much the same as in the case just discussed, though with certain differences. Here the department representative is always present, with voting power on all committees whose decisions may affect rates, though he rarely actually votes, preferring to leave the department complete freedom at the next stage. He does not hesitate to join in the discussion and to indicate dis-

agreement while a proposal is in the committee stage, or to present definite requirements on certain points. Of course, much depends on the personality of the department representative and of his chief, the incumbent commissioner. When a decision is reached, the proposed action, with a full explanation including all supporting statistical data and arguments and a proposed effective date, is submitted for formal approval. If there is disagreement, the commissioner may call a hearing and accept briefs from both sides, before giving or denying approval.[1]

Since the commissioner may withdraw approval already given, it follows that he may initiate changes, and there are many cases on record where he has done so. Individual complaints are handled much as in the case of supervision of bureaus without formal responsibility for the rates themselves. Indeed the major difference between the two methods of supervision lies in the formal submission for approval in advance in the latter case, such action not being necessary in the former.

As indicated in the preceding chapter, approval of rates implies that the expense loading is adequate and involves the enforcement of expense limitation. In at least one case the companies were required to form their own organization for forcing such limitation.[2] Special reports are also required to ascertain that these limitations have been observed and what the actual expense has been.[3]

Supervision of Policy Forms.—The supervision of policy forms involves no special problems of machinery or technique. The major problem of the commissioner's representative in this work is matching wits with those (fortunately relatively few)

[1] The procedure is characteristic of the supervision of workmen's-compensation-insurance rating bureaus. In other fields the control is more remote. The department representative does not usually attend committee meetings, and the department acts only on matters as they are completed and presented for approval. The rating bureaus covering such fields are, however, periodically examined and complaints are investigated as they are presented.

[2] See MICHELBACHER, G. F., "The New Rules Regarding Acquisition and Field Supervision Cost for Casualty Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. IX, pp. 242*ff*.

[3] See VAN TUYL, H. O., "A New Experience Exhibit for Casualty Insurance Companies," *Proceedings of the Casualty Actuarial Society*, Vol. X, pp. 17*ff*.

who morally have no right to operate an insurance company, but who manage to keep just within the law and eternally try to find forms which will nominally satisfy the law but which are easily misrepresented as more valuable than they actually are. Unfortunately, some gentleman of the law can always be found, whose moral right to practice his profession is on a plane with their own, and who, for a fee, will lend his technical skill to attain their malodorous ends.

As noted in Part II standard-policy forms are required by law in some fields and in others the whole form is not standardized, but standard provisions are required. Frequently also the laws specify the size or character of the type to be used for certain provisions. Unless company forms are printed from plates, which is not usually the case, approval of each printing or edition of a form is necessary to assure compliance. There is thus a substantial volume of detail work for which suitable procedures must be worked out, and notice of them must be given the carriers to keep it running smoothly. Incidentally, no small amount of filing space is required. The carriers also at times encounter difficulties when two or more departments take divergent views with regard to a form intended for general use in several states.

Deposits of Securities.—In many states domestic companies are required to deposit securities (usually government bonds), equal in value to their capital, with the state. An alien company is always required so to maintain the *deposit capital* of its United States branch in the state in which it is domiciled. Nearly every state requires a deposit of securities or the filing of a surety bond or bonds for some one or more purposes, *e.g.*, the California requirement relative to workmen's compensation loss reserves[1] and in the same state the requirement of a bond or deposit to secure the payment of taxes. Some states require domestic life-insurance companies to deposit securities equal to their total reserves. Some states require all foreign companies to make a deposit for the protection of their obligations to domestic credi-

[1] See p. 231*n*. The payment of similar deferred benefits into the fund administered by the New York Industrial Board is not a deposit but an absolute payment, and the special fund takes over the obligation (see p. 531).

tors. These deposits are not proportionate to the obligations but are fixed amounts.[1]

Deposits for special purposes other than the liquidation of incurred but deferred liabilities tend to defeat the primary purpose of insurance, collecting through premiums a fund to meet losses wherever they occur. Earmarked deposits of this kind, not for the benefit of all policyholders and not to cover liabilities for which a reserve is carried, are usually treated in examining companies and auditing statements as nonadmitted assets.

Deposit requirements are an annoyance to the carriers for several reasons. The scattering of assets over the country out of their immediate control requires special records to keep track of them and see that interest is collected and properly remitted. If for any reason a carrier wishes to dispose of a deposited security, it must arrange a substitution, at best an annoyance and perhaps a cause of loss because of inability to make prompt delivery. There is a chance of loss in transmittal. On an examination of the carrier, certificates must be secured from the custodians to exhibit to the examiners who cannot include them in their physical inspection of securities in the carrier's safe-deposit box. Most state treasurers are bonded, but the bond may not be adequate to cover all funds and securities in their custody, so that there is a chance of loss from that score. The carriers, therefore, prefer to have the law permit a surety bond as an alternative. However, even when the law allows that alternative, some companies deposit securities.

Usually the deposit must be in negotiable securities which the state authority is authorized to sell if the carrier fails to meet the obligations to secure which they are deposited. In the meantime they are held in trust and remain the property of the carrier which is entitled to receive the interest on them. Usually, where the law requires a deposit by an insurance carrier for any purpose, the deposit passes through the insurance department for check before going to the state treasurer. Sometimes, but not usually, the insurance commissioner is the custodian.

[1] In two states the deposit is only $10,000. This is so ridiculously small relative to potential liabilities that it appears to be a carry-over from earlier days of small things which has been allowed to remain on the statute books through inertia.

Workmen's Compensation Security Funds.—The nature of workmen's compensation benefits is such that the state has an unusual interest in the assurance of their payment. To this end a number of states have had statutory requirements of a surety bond or deposit of securities from out-of-state carriers to guarantee the present value of future payment under awards against them for such benefits. During the recent depression some companies writing workmen's compensation insurance were found insolvent and the surety of their bond also insolvent, leaving beneficiaries unprotected. This led to further pressure for restricting the writing of workmen's compensation insurance to a monopolistic state fund.[1]

A proposal for a monopolistic fund was vigorously pressed before the Legislature of New York in 1935, but an alternative was adopted. The carriers are now required to pay the present value of all awards for death and permanent total disability into a special fund under the control of the Industrial Board. Other claims are to be paid direct by the carrier. In order to assure the payment of these claims in the event of insolvency, stock and mutual carriers are required to make payments into other special funds, the Stock Workmen's Compensation Security Fund and the Mutual Workmen's Compensation Security Fund, for stock carriers and mutual carriers respectively, which are administered by the Superintendent of Insurance. Since 1935 payments of 1 per cent of the net premiums written on workmen's compensation insurance in New York have been made into these funds. Each fund has reached its contemplated maximum, which is 5 per cent of the outstanding New York workmen's compensation losses of its group of carriers. In the case of the stock fund, payments have been discontinued, to be resumed whenever the amount of the fund falls below the statutory requirement. The mutual fund operates on a revolving basis and, having likewise reached its contemplated maximum, mutual carriers will continue to contribute 1 per cent of current premiums but will receive refunds of payments made in earlier years. Both funds must be maintained at their maximums, and accumulations must be resumed after deficiencies resulting from insolvencies.

At the present writing similar proposals are under considera-

[1] See p. 303.

tion in other states. There seems to be a fair prospect for further extension of the system. It has even been suggested by the Superintendent of Insurance of New York that the principle should be applied to other lines of insurance for the sake of the good name and reputation of the insurance business as a whole, but this suggestion was not well received. Its critics alleged that it would be unfair to the conservative well-managed companies, calling upon them to guarantee the contracts of their more daring competitors.[1] Until rates and practices throughout the country are much more carefully standardized than they are at present, this argument seems to have merit. There is considerable resemblance between this proposal and the guarantee of bank deposits, earlier attempts at which failed.[2] Similar funds have been set up in some states for automobile-liability insurance.

Liquidation Bureaus.—Despite the best supervision, some rascals will pass the guard, and honest mistakes will happen so that failures must be expected. Formerly these cases were put through the ordinary receivership procedure. The "winding up" was expensive and long drawn out. The experiment of giving the commissioner the duty of liquidating insolvent companies was first tried in New York, and a liquidation bureau was

[1] In 1941 the New York insurance law was amended by adding a provision setting up a nonprofit corporation, to be known as "The Life Insurance Guaranty Corporation," composed of the Superintendent of Insurance, ex officio, and one representative from each legal-reserve life-insurance company incorporated in New York and licensed on Jan. 1, 1941. Each representative is known as a *director*. The purpose of the corporation is to guarantee the fullfilment of life-insurance contracts issued by the companies represented in it. It may reinsure contracts or otherwise act to protect them. The directors are authorized to raise by assessment upon the companies represented, pro rata upon their admitted assets, a guaranty fund in the amount deemed necessary for its purpose, not in excess of $25,000,000. In 1942 one of the smaller companies was in financial difficulties by reason of shrinkage of real-estate values. The Corporation levied an assessment against all the other domestic companies, $1,500,000 was paid into the Fund, and the Corporation became responsible for the investment of the monies. It issued to the insurance company a guarantee that the monies would be released if the occasion demanded. The company was then allowed to take credit in its annual statement for an amount equal to the guarantee.

[2] For discussion of these earlier attempts and the present plan of Federal Deposit Insurance see pp. 295–297.

formed within the department. The results have been so satisfactory, both in reduction of time and expense involved and increase in recovery for policyholders, that several states have provided for the appointment of the insurance commissioner or his representative, as receiver of insolvent insurance companies. In general, however, liquidation bureaus are not maintained, special representatives being appointed as cases arise.[1] Though not quite so effective as a continuous liquidation bureau, yet this method has resulted in much saving in comparison with the ordinary receivership.

Extraterritorial Regulation.—Although the laws of each state govern the operations within its borders of all carriers admitted to do business, they extend to all operations of companies organized under them. Thus, the New York law places limitations on acquisition expenses of the life-insurance companies of that state. These limitations must be observed as to all the business of such companies, not merely as to their New York business. So also, if the law of any state requires of a mutual company that its policy carry a provision relating to the liability of policyholders to assessment, all the policies of the company, wherever issued, must carry that provision. The standard-policy laws of most states permit companies to include such required clauses.

A company domiciled in a state whose laws provide for limitation of expense may be at a disadvantage elsewhere where its competitors are not so restricted.

The effect of the application of the state law, on the one hand to the operations within its borders of foreign as well as domestic carriers, and on the other to all operations of domestic companies, gives great scope to the laws of states having large insurable risks attracting foreign carriers to operate there and also having many domestic carriers doing business over a wide territory.[2] To a considerable extent the entire operations of a foreign carrier must compare to the standards of a state to which it is admitted.

[1] Lest it be thought that the New York action implies weakness in the companies of that state, it should be noted here that the supervision of that state is probably the best in the country, and its carriers as good as the best. Its size and commercial importance mean more companies, and even a smaller ratio of failures may yet give a large absolute number.

[2] *E.g.*, New York.

A strong insurance department in such states has a beneficial effect on policyholders' interests far beyond its borders and sets the example for other states. To the extent that in this way it reaches into the states having weak laws and poor administration it tends to overcome that weakness.

Reciprocal and Retaliatory Laws.—Some states provide, as to taxation and other regulation, for reciprocal requirements and restrictions. If, for example, state A having a *reciprocal* law charges no fee for filing an annual statement, but state B charges all companies, including its own, $25, then state A would charge all companies from state B $25 for that service.

A *retaliatory* law is of slightly different form. It provides for retaliation only when a regulation is imposed in another state on companies of the state having such a law, which is greater than is imposed on its own companies. If, for example, Texas taxes its own companies 2 per cent of their premiums but taxes those of other states 4 per cent, then in New York or California, Texas companies would be taxed 2 per cent more than domestic companies. Retaliatory or reciprocal laws are found in the statutes of nearly all the states. They constitute a weapon of defense against unfair discrimination but may be, and have been, invoked by weak commissioners to protect their friends against entirely proper regulation. The threat of retaliation, conveyed to the companies domiciled in the state proposing to examine or bar a company from another state, may cause such pressure to be brought on the commissioner as to stop his proposed action.

Sometimes such laws have an effect not contemplated when they were passed. In a western state legislature a bill was introduced to provide for retirement pensions for firemen by a tax on fire-insurance premiums. Presumably to forestall the opposition of local companies, it was provided that they should be exempt from the proposed tax. If the bill had passed, the burden on them of additional tax in other states under reciprocal and retaliatory provisions would have been several times the proposed local tax. Therefore, the local companies led the fight against the bill, which was defeated.

Since the 1944 decision of the Supreme Court there has been a tendency to repeal or modify such laws to avoid the charge that the state unfairly discriminates against insurers in interstate commerce.

TAXATION OF INSURANCE COMPANIES

The insurance department does not now usually collect all the taxes on insurance companies, but does exact fees that are in the nature of taxes and generally receives and checks the tax returns against other reports, turning them over to other officials for the actual levying and collection of taxes.

Present Taxation.—Taxation of insurance companies is a much mooted question as to both extent and method. Before discussing principles, it is well to note the manner of taxation at the present time. The taxes paid to the state fall into several categories, such as

1. Fees paid the insurance departments for company licenses, a direct privilege tax.
2. Fees paid the insurance department for agents' licenses, an indirect privilege tax.
3. Fees paid local communities for agents' licenses, and sometimes company licenses, an indirect privilege tax which is now not often allowed, the state law requiring that its license be accepted as according the privilege of operation in all parts of the state.
4. Fees paid the insurance department for filing statements and papers, and for certifying documents, an indirect privilege tax to the extent that the law requires the filing, and a service charge in other cases.
5. Fees paid the office of the Secretary of State for filing documents if separate filing is required, an indirect privilege tax.
6. Expenses paid the insurance department for examinations, when the law requires that the expense of examination be borne by the company examined, an indirect privilege tax when the examination is required by law.
7. Taxes on real and personal property within the state.
8. A percentage tax (usually about 2 per cent) on premiums collected in the state. Sometimes the amount paid under this item is reduced by the amount paid under the preceding.
9. Taxes to the federal government as income taxes.

Carriers' Views on Taxation.—Although the maintenance of the insurance department is for the protection of the citizens, it is of advantage to the good companies because of the protection against the unfair competition of the unscrupulous, and the protection it affords the business as a whole. Therefore, it is deemed just that the companies pay the expense of maintaining the department, as one imposed on the state by their existence.

It is also thought just to tax the proprietary interest in any insurance enterprise to the same extent, and in the same manner, as the proprietary interest in any other business is taxed. But

a premium tax is an indirect tax on policyholders and calls for a corresponding loading in the premium. The company is merely a reservoir and control system, receiving its funds from the policyholders in premiums and the interest on premiums held in reserve, and paying them out in losses and the necessary expense of operating the system. If the outgo is raised by a new stream to the state, the inflow must be correspondingly raised.

Further, it is alleged, this tax is not only an indirect tax discriminatorily laid on those who take out insurance, it is a tax on thrift, discouraging action which is much for the public benefit, since those who protect themselves and their dependents by insurance are forefending against their later becoming public charges. Therefore, it is argued, premium taxes should be abolished.

At the present time, the fees collected in all states far exceed the amount expended in the maintenance of the insurance department. Rarely is any tax laid on the proprietary interest except the federal taxes and taxes in one or two states which do not levy a premium tax on their own companies but tax their capital stock. The effect of reciprocal and retaliatory laws is to increase further the taxes charged.

One of the serious complaints of the companies is against the inconsistencies in the premium tax. Not only do the rates differ from state to state but the bases of the tax also differ. For example, some states allow reinsurance premiums paid to other companies to be deducted from the gross premiums, but require premiums received for reinsurance to be reported for taxation. Others do just the reverse. These inconsistencies become more burdensome and complicated when reciprocal and retaliatory laws also apply. A considerable burden of work and expense is imposed on the companies in keeping track of the various requirements and arranging their accounts so that they may make the required returns for taxation.

Contrary Argument.—In answer to the companies' arguments, it is asserted that all taxes are taxes on thrift and that, as evidenced by our tariff laws, our policy has been to favor indirect taxation. To the argument that such taxation discourages insurance and thus works to public disadvantage, the answer is that the premiums any individual pays are small on the whole, and the amount of the tax of only 2 per cent is so small that it is not noticed.

Practical Situation.—To the author's mind the companies' position is logical and sound but cannot be expected to prevail in practice, though the state may be induced to spend a larger part of the fees charged through the insurance departments on the maintenance of those departments and the improvement of their service.

The reasons for the forecast are as follows:

1. The present premium taxes bring in a large revenue that is easily collected at little or no expense.
2. The complaint against the taxes does not come from the voters and therefore carries little weight.
3. The reduction in insurance rates that would follow the removal of the tax would be too small to interest policyholders.
4. The increase in other taxes necessary to replace the revenues derived from the taxation of insurance, unless levied on another group in a similar indirect way, would bring much stronger protest than now arises over insurance taxation.

SUMMARY

1. The insurance department is usually presided over by an elective or appointive official who lays down its general policy and is assisted by a more permanent staff in the details of administration.
2. Sometimes the insurance department has charge of the granting of corporate charters to insurance carriers. If so, the procedure for incorporation is prescribed by statute, and compliance therewith must be checked before the charter is granted.
3. Before an insurance carrier may operate in any state, it must procure a license, or certificate of authority, from the insurance commissioner under the terms prescribed by statute. This applies to companies of other states of the United States, known technically as "foreign" companies, and of other countries, known technically as "alien" companies.
4. Brokers and agents must procure licenses from the insurance commissioner.
5. Under certain limited conditions, brokers may place insurance in unauthorized or "unadmitted" companies, but otherwise there are severe penalties for representing or placing insurance in such companies. Always there are penalties for operating without a license.

6. Under certain conditions, when the operation of a carrier or agent is contrary to public interest, certificates of authority and licenses may be refused or revoked.

7. The insurance commissioner is charged with general observation of the conduct of those engaged in the insurance business, and prosecution through the district attorney or attorney general of violators of the insurance law.

8. The most important purpose of the insurance department is to assure solvency of the carriers, and to that end

- *a.* They are required to file very complete annual reports which are subject to audit in the department and open to public inspection.
- *b.* The commissioner is often given the power to require disposal of improper investments.
- *c.* The commissioner is authorized and required to make examinations to verify the statements, and further to inform himself and the public.

9. The insurance department is open to the public who may seek its reasonable assistance in adjusting grievances and procuring fair treatment, though the department has not the functions of a court or a legal-aid bureau.

10. Where the commissioner has jurisdiction over rates for insurance, an appropriate bureau or division of his office must be organized to handle the details.

11. Often the insurance department has much detail work in connection with deposit of securities for the benefit of policyholders.

12. In some states the liquidation of insolvent companies is made a function of the insurance department.

13. Policyholders of insurance companies are indirectly taxed through a variety of methods, which seem to place upon them an undue proportion of the state's tax burden, but the practical situation is such that they are not likely to be relieved therefrom.

References

See references for Chap. XXVII.

Annual Reports, Various state insurance departments.

Insurance laws of the several states, usually obtainable in convenient form from the offices of the insurance commissioners.

Part VI

INSURANCE IN STATE POLICY

INTRODUCTION TO PART VI

The preceding parts of this book (except the discussion of workmen's compensation) have been concerned with the institution of insurance as developed by the voluntary action of individuals who seek to relieve themselves of risk by transferring it to insurance carriers. That such relief from risk has been of public benefit is wholly incidental and unintentional. With such voluntary insurance, a privately controlled risk carrier is naturally associated, and, as the granting of monopoly rights to private enterprises has long since passed out of fashion, the further association of competition is naturally assumed. Consequently, many of those engaged in the insurance business look upon compulsory insurance with a monopolistic carrier as inconsistent with sound insurance principles.

If a sufficiently large body of similar risks is brought together and the nature and degree of risk are approximately constant, the law of large numbers will eliminate uncertainty, the essential element of risk, and produce a fixed, or approximately fixed, cost. This law is no respecter of persons. It operates for the monopolistic state-operated fund and the competitive private enterprise without discrimination. All that is essential is similarity of the individual risks in nature and degree, and the amalgamation of a sufficient number.

Beneficial to public welfare as voluntary insurance by individuals seeking to protect their own interest has been, there yet remains a heavy social burden due to risks still carried by individuals who are not able to carry them without thereby creating for the state grave problems of poverty and its consequences. Statesmen have seen that these problems

may be mitigated, if not solved, by application of the insurance principle; have made its application compulsory as to certain risks and classes of society; and have provided, or designated, the proper carriers. Extensions of the compulsory principle are under consideration. Part VI is devoted to a necessarily brief consideration of these applications, and proposed applications, of the insurance principle in state policy. To such schemes for solving the problems of disability among the industrial class due to work accidents, sickness, invalidity, old age, and unemployment, the general term "social insurance" is applied.

CHAPTER XXIX

SOCIAL INSURANCE

In view of the many governments that have adopted, in whole or in part, programs of social insurance, the numbers of persons brought into the schemes, and the important place that such schemes occupy in the social and economic life of these nations, a text attempting to set forth fundamental principles of insurance and their present-day applications could hardly be regarded as complete if it contained no reference to social insurance. On the other hand, owing to the differences in social and economic conditions and background, many important differences are found in the details of the schemes adopted in the several countries. Adequately to deal in detail with the topic would require a substantial book devoted to it alone. It is therefore impossible to discuss details within the scope of a single chapter. Nor is it important to do so in this book, the primary aim of which is a presentation of the application of insurance principles in the United States at the present time. It will be sufficient to point out the conditions that gave rise to the development of social insurance, the ends sought in introducing it, the fields it covers, and the essential differences between its fundamental concepts and those underlying the practice of private insurance.

Poverty Not Always Due to Lack of Thrift.—It has always been more or less the fashion to blame the miseries of the poor to a large degree on their own lack of thrift, foresight, and discretion.

External evidence has seemed to support this view; large families, drunkenness, occasional patent extravagance. It is natural also to draw this conclusion, since it flatters the vanity of those who have avoided poverty. Further, the rise from dire poverty to the highest positions has occurred with sufficient frequency to lead many to conclude that any who would could do likewise, and that where the person failed the will was lacking.

But modern science and research have shown the fallacy of this complacent view. The "poor whites" of the South may seem "jes shif'less" and "no 'count," but when the hookworm and pellagra have been eradicated, they present a different appearance. Drunkenness is a sodden vice, but it is not wholly confined to the poor and appears more excusable when viewed as the only ready escape from the drab monotony of factory and slum. And so, within the last half century, the problem has been attacked with less censure and more understanding.

Poverty Often Due to Insurable Contingencies.—Modern study and investigation have shown the need of better housing, working conditions, and recreation facilities, and have tended to bring them about. It has also been shown that much poverty and suffering which react to the injury of the public are due to the results of contingencies for which those exposed have not made adequate provision, either from lack of means or failure to appreciate the need. These contingencies are those to which all are exposed and for which more or less adequate provision is made by insurance. They have been indicated in Part I of this book, but may well be repeated here.

1. Premature death of one having dependents:
   a. From occupational accident or disease.
   b. From other accident or disease.
2. Disablement of a temporary nature but considerable duration:
   a. From occupational accident or disease.
   b. From other accident or disease.
3. Invalidity (permanent disability):
   a. From occupational accident or disease.
   b. From other accident or disease.
4. Superannuation (unemployability due to age).
5. Unemployment.

With the possible exception of unemployment, and probably, within reasonable limits and under suitable conditions, even

including unemployment, all these contingencies are of such a nature that the risk can be eliminated through the application of the principle of insurance.

Why Insurance Is Not Voluntarily Carried.—There are many reasons why insurance against these risks has not been voluntarily carried by persons of limited economic resources. Foremost, undoubtedly, is the limitation of income. When every penny has to be counted, lest some that will later be required for food be spent for unnecessary things, with a still unsettled balance at a grocer's for food during the last shutdown of the mill, and with rumors of dull times and another shutdown coming, the harrassed housewife can see no possibility of paying out money to insure John's life. "He's strong and well now, and the boys are growing and will soon be able to help should the need arise." "He may be killed in an accident? Pray God not, but why go hungry now to save possibly having to go hungry later when we may not be in need? Besides, the rate is out of reason." "Yes, a few pennies a week for a little insurance money to bury us with. We must do that, for we could not think of a county burial, but that is hard enough." Such might be the replies, were the proposal that voluntary insurance be taken against these contingencies to be advanced seriously in a laborer's family.

Cost of Private Insurance.—Even in the case of a family in somewhat better circumstances than those pictured above, and with an understanding of the value of insurance, the cost of private insurance would be generally considered beyond reach and would unavoidably be very high. For such insurance would have to be sold for convenient small payments at short intervals. The selling cost would be high, for it would involve door-to-door canvass, as in the case of industrial life insurance. The collection cost would be high for the same reason. It could hardly be handled by mail. The lapse rate would be excessive, as it is in industrial life insurance. The class of agents who could be employed at necessarily low rates of pay would not thoroughly understand or properly explain the contracts and, even if there were not downright misrepresentation, there would not be a clear understanding of the benefits, with the consequent unallowable claim to breed further distrust. The discovery of policy limitations would tend to discredit the whole institution of insurance.

Happily (or perhaps unhappily) it is not necessary to draw on the imagination to see this. Actual experience with industrial life insurance shows its unavoidably high cost even when ably and honestly conducted. Experience with accident and health insurance for the industrial classes under limited policies has shown abuses. The dishonest in that field have at times in the past shamefully exploited the workers.

Cooperative Insurance Not Satisfactory.—Cooperative schemes have been tried as a means of providing insurance against these contingencies. Abroad, some of them have had marked success and have been developed into important agencies in the social-insurance systems. Some, too, in the United States have an honorable record of service. But the life-insurance associations have generally failed by reason of their disregard of scientific principles, and reliance upon improperly graduated assessments. Both with these and with other associations, the need of someone to manage the association, and the ability of a glib talker to secure proxies and establish control for his own private benefit, have often led to a subversion of their real purpose and to such abuse as to weaken confidence.

But the most serious failure of cooperative schemes of insurance to meet the needs of the industrial classes is found in the incompleteness of their coverage, as respects both the proportion of the population joining in them and the extent of the risks covered. Only the more thrifty, those whose need perhaps is the least, make such voluntary provision, and even among these there is a wide range of unabsorbed risks left for the individual to carry himself.

The conclusion seems inescapable that private insurance has not functioned so as to furnish to the industrial classes adequate coverage against the risks to which they are exposed, and probably never can so function.

Interest and Responsibility of Government.—If one adopts the strict doctrine of the laissez-faire philosophy, that in the long run natural forces work out their own cures for evils which develop and that greater evils will be caused by interference, then all this will seem very regrettable, but unavoidable. But in no civilized country of the world is that philosophy the governing principle. Whatever has been the theory of regulating commercial enterprise, whenever a public need has arisen which

can better, more conveniently, or more justly be met by the government than by private enterprise, pressure has been brought upon government to meet it. Government has shown an increasing tendency to do so. Perhaps the earliest function to be so taken over was the coinage of money. But there have been many others, the post office, street lighting, water supply, to name but a few.

Is this problem purely a problem of the industrial classes, or is it affected with a general public interest? In those countries which have adopted social-insurance schemes, the answer has been that there is a general public interest warranting governmental action. Not only has it been felt that there is a sufficient interest to justify adoption of the scheme, but the view has been that the interest was sufficient to justify financial support of the scheme, at least to the extent of liberal appropriation for expenses, and generally of contribution toward the benefits.

What is the nature of that interest? To begin with the most mercenary and least humane aspect, the state must bear the expense of public poor relief, including the maintenance of almshouses, charity hospitals, and like institutions. Crime is closely associated with pauperism; unsanitary and depressing surroundings bring other social problems; and the maintenance of insane asylums, prisons, and police forces is a public expense. To the extent, then, that the elimination of the risks tending to cause poverty or pauperism reduces these needs, the government has a direct financial interest in promoting that elimination.

But the government's interest in the prevention of pauperism is broader. Pauperism has been justly characterized as a "social disease, radical, contagious, and hereditary. Its ranks are continually supplied from above, and every accession suggests a possible horde of Ishmaels or Jukes."[1] Although it produces directly the monetary costs just noted, by lowering standards it tends also to involve the well-being of society as a whole, exposing its members to the danger of epidemics and the violence of radical discontent. Just as government furnishes education free to all for the benefit of the whole community and considers the cost well spent, so it can well afford to encourage and assist

[1] Lewis, Frank W., "State Insurance," p. 17.

in the elimination of these risks, because of the benefit that accrues to society as a whole.

Industry Has a Responsibility and an Interest.—As already argued in the discussion of workmen's compensation, the employer of the individual worker and the employing class, as a class, are felt to have a responsibility to the extent that employment may involve risk. This is clear and now recognized at least to some extent by all of the United States, as to industrial accidents and industrial disease. But does the responsibility stop there? Is it any less the responsibility of industry that, because of the arduousness of his tasks, a worker is no more fit to continue work beyond age fifty, than he would be, were he disabled at that age by an accident? If the current wage permitted an adequate provision for retirement at a reasonable age and the individual spent it in riotous living, there would perhaps be no responsibility on the employer. But it requires very little calculation or reflection to recognize that modern industry does not pay a wage that permits such saving. And though disease that may cause invalidity or death may not be traceable through an unbroken chain to the occupation, may it not be found that conditions of employment have prevented the building up of physical resistance that would have enabled the victim to throw it off?

Denying wholly for the sake of argument such responsibility, does not business have a direct and positive interest in promoting the elimination of such risks? There is reason to believe that it has. Business is always seeking greater economy in production. Alertness and skill of workers protect machinery from damage and make for its longer life. They protect materials against waste by spoilage and permit faster operation and the production of better goods. American industry has been slow to recognize these facts, but modern labor management has come to a full realization of them. Absence from work due to disease forces replacements, permanent or temporary, and lowers efficiency. If means can be found, by provision for adequate treatment, to shorten the period of illness or prevent it, there is clear gain. In general, assurance of reasonable freedom from these risks should free the worker from worry and enable him to give more undivided attention to his work.

Along this general line it has been reasoned, in the countries

adopting social-insurance systems, that it is proper for both industry and the government to share in the cost of providing insurance against these contingencies. Experience has shown that direct gifts to persons and classes in distress tend to pauperize. Hence the beneficiaries themselves should not be absolved from contribution but should bear their own share of the cost of insuring against some, if not all, of these risks.[1] Complete insurance against any one of the risks should not be provided, since it is important to retain the interest of the individual in preventive effort, and also to prevent malingering, an evil which seems to have developed under these systems, though to what extent it is probably impossible for anyone precisely to estimate.

Compulsion Essential to Success.—Advertisement of the most fantastic scheme of speculative investment will bring plenty of responses, often from those on the border line of poverty. But a carefully worked-out plan of insurance with substantial government assistance, if offered for voluntary acceptance, will for the most part be ignored. The working man hopes for an old age of respectable comfort and wishes to provide it. The examples of those fortunate few who have struck oil, or otherwise rapidly achieved wealth, are so well known that the "get-rich-quick" scheme has an alluring pull. But the amount that can be provided through the sound scheme seems so pitifully small in comparison with its cost that it hardly seems worth the effort. Abroad as in America,

> . . . saving is necessary to provide for the rainy day, for loss of earning power due to illness or accident or old age, but against these needs is the insistent demand of the present for better food, for better living conditions, for educational opportunities for children. It is not fixed and stationary. It is always expanding.[2]

Against this tendency of current expenses to press upon income, fear of the future is all too weak a check. The average individual is an

[1] Consideration of the question whether and to what extent the employers' or employees' contributions may be passed on to others through wage and price adjustment would require too extensive a digression for this book. The careful student should not overlook the possibilities. But, even if the burden of contributions is shifted in large part, there may be valid psychological reasons for assessing them on each of the groups. Direct contribution promotes interest in proper conduct of the plan.

[2] Seager, Henry R., "Social Insurance," p. 10.

optimist. He does not expect to be out of employment, to be ill, to be injured in his work, or even to grow too old to work.[1]

But if only the provident or pessimistic few take advantage of a scheme of insurance, subsidized or not, to provide for these risks, the problem remains unsolved. It is the blind optimist who creates the problem. Were he alone to be the victim of his optimism, and an example to others of its folly, perhaps individualistic indifference to him might be the proper course. But he is not alone. His fall carries with him those dependent upon him. Even though it is a matter merely of a dependent old age, the burden of his dependence may bring down those who, by their filial sense or the law's requirement, are forced to care for him.

Since the aim of social-insurance schemes will be defeated if it is left to individuals to take advantage of them voluntarily, compulsory participation on the part of all eligible is an essential part of such schemes.

Monopolistic Carriers General.—Although the adoption of social insurance as a state policy is a definite act of legislation, usually there has been more or less preparation in the evolution of voluntary and cooperative effort. In individualistic countries like the United States and Great Britain, the institutions created by these efforts are factors that must be reckoned with, and they may have to be made the carriers of some of the risks under the social scheme[2] but, when the government makes any such scheme compulsory and requires workers and employers to defray a part of the cost, it must see that that cost is kept at a mimimum consistent with the benefits granted. Any opening for private profit and the expense of competitive selling cost will bring severe criticism. Hence the carrier under such a scheme is usually monopolistic for its region or industry, if not for the nation.

Collection Costs.—Collection costs must also be minimized, a result most easily accomplished by collection through the employer, who may deduct the employees' shares from wages.

[1] *Ibid.*, p. 11.

[2] Notably the "Friendly Societies" under the British National Insurance Act.

The employer will then give a receipt to his employee, either by buying stamps and pasting them on the employee's card or by some other means.

Definition of Social Insurance.—A sharp definition of social insurance as distinguished from private insurance is not easy to frame. Most writers on the subject have tended to describe schemes and their philosophy in terms similar to the preceding paragraphs. Armstrong has defined it in the following language:

> The term Social Insurance has come to have an accepted technical significance despite the protests of a certain group of insurance men who stoutly maintain that all insurance is social insurance. It signifies insurance participated in by the organized community against the various contingencies that cut off the worker's earning power and threaten him with economic disaster. These contingencies are sickness (including maternity), accident, unemployment, invalidity, superannuation, and premature death.[1]

Blanchard goes further. His definition follows:

> Social insurance is any form of insurance in which the government goes beyond the regulation of practices and the dissemination of information. It may do so by compelling insurance, by shifting the cost, by subsidy, or by becoming itself an insurer. To the extent that it acts in any one of these directions, insurance becomes social insurance, and I should include within its scope compulsory automobile insurance, governmental schemes of war-risk insurance, governmental crop insurance, as well as the more commonly recognized workmen's compensation, unemployment, old-age, and disability insurances.[2]

He might well have included bank-deposit insurance, hail insurance, and perhaps others.

A briefer, though less precise definition, but one which emphasizes the objective is: "Social insurance is the attempt of government to apply the principle of insurance to the prevention or alleviation of poverty." W. R. Williamson, Actuarial Consultant of the Social Security Board, has summarized its philosophy in the term "social budgeting."[3]

[1] "Insuring the Essentials," p. 3.

[2] Presidential Address, *Proceedings of the Casualty Actuarial Society*, Vol. XXIX, p. 1.

[3] *Proceedings of the Casualty Actuarial Society*, Vol. XXIV, pp. 17*ff*.

These broader definitions would probably justify giving the title Social Insurance to Part VI of this book. The discussion in this chapter is confined to the narrower field embraced in Armstrong's definition which follows the common European conception of the meaning of the term.

The essential features of a complete social-insurance scheme are

1. Insurance of the industrial classes against the risks of
   a. Death.
   b. Disability.
   c. Invalidity.
   d. Old age.
   e. Unemployment.
2. Insurance compulsory on all members of the eligible class.
3. Sharing of costs in varying degrees, according to the risks covered, by the insured workers, the employers, and the government.
4. Insurance in specially created, or designated, carriers.
5. A scheme of collection through employers to avoid expense.

Beginnings of Social Insurance.—The credit of first introducing a system of social insurance on a national scale goes to Germany.[1] It is often said that it was introduced by Bismarck as a sop to the socialists. But in the author's opinion this shows a poor understanding of the essential philosophy of the great chancellor. A more accurate explanation would seem to run along the following lines: Voluntary organizations for furnishing these insurances had existed for some time, in some cases nearly a century. There was evident need of such service and pressure for it. Compulsory insurance seemed inevitable as a part of national industrial development. It would tend toward a more efficient and contented labor class. For the nation to sponsor and control the social insurance scheme was in accord with Bismarck's ideal of a great unified German Empire. It was better for him and his party boldly to sponsor it than to have it thrust upon them. "This policy was not regarded as a break with previous traditions, but was considered rather as a logical development of institutions for the care of disabled workmen made necessary by the change in conditions brought about by modern industrial methods."[2] Prior to the passage of the

[1] See *24th Annual Report of the United States Commissioner of Labor*, Vol. I, p. 977 (1909).

[2] *Ibid.*, p. 997.

national laws " . . . many of the local governments throughout the country enacted laws requiring specified workers within their areas to pay regular contributions to the communal treasury from which was paid sickness and accident relief."[1] The system was urged on the Reichstag as a duty of the state by a message of Emperor William I, on Nov. 7, 1881. It was not all established at once. In fact, the scheme did not include unemployment insurance, which was not added until after 1925. The other parts were adopted in three laws. The first, passed June 15, 1883, to come into operation Dec. 1, 1884, provided for sickness insurance. The second, passed July 6, 1884, effective Oct. 1, 1885, established the principle of workmen's compensation for industrial accidents and provided insurance for it. The third, passed June 26, 1889, effective Jan. 1, 1891, provided old-age and invalidity insurance. All three have been considerably amended, but the basic principles have been maintained.

German Scheme.—For the administration of the law existing institutions have been used as far as possible, but each insurance carrier has a monopoly of its field.

The sickness insurance is primarily carried in funds organized by communities, though other funds are operated whose membership is selected on industrial or occupational lines. In all cases the charges differentiate costs according to occupation. These funds are mutuals, though restricted by the national laws. The employers who contribute to these funds are entitled to representation in the annual meeting and on the board, in proportion to their contributions, the representation of no one employer to exceed one-third of the total. The fund must provide the minimum benefits required by law and may provide additional benefits, but there are limits beyond which the dues may not go, which restrict the additional benefits.

Two-thirds of the cost is borne by the employees and one-third by the employers, but the sickness funds provide for the first 13 weeks of disability due to an employment accident.

The accident insurance (workmen's compensation) is administered by trade associations, each employer being required to belong to the association covering his industry. The cost is borne solely by the employers. But the assessments are not

[1] *Ibid.*, p. 978.

required to be uniform, each association being permitted to establish graduated rates of contribution according to degree of risk.

The old-age and invalidity insurance is provided by "institutes," organized on a territorial basis, which, like the other carriers, are self-administering mutual organizations closely regulated by the National Insurance Office. Assessments are according to wage classes, the employer and employee each paying one-half the prescribed rates. The central government makes a fixed contribution for each pension in force, provides the services of certain officials in administration, and gives free postal service.

These institutes provide pensions for old age and invalidity, including permanent sickness and sickness lasting more than 26 weeks, at this point taking the cases over from the sickness fund. There are other benefits in the way of medical and hospital services and in some cases refund of contributions, *e.g.*, to dependents in the case of death.

As all these institutions (accident, sickness, and invalidity) are monopolistic and compulsory, it is not necessary to set aside present-value reserves. Only moderate reserves against temporary fluctuations are set up. As the benefits extend naturally over a term of years, the assessment costs have risen with the increased age of the system. But as all employers in the same industry were similarly affected, it did not place a competitive handicap on any one. Ultimately they may be expected to reach a stable basis, though naturally war and its consequences have caused a postponment of this result.

The systems are knit together, since a part of the workmen's compensation benefits is provided by the sickness funds, and a part of the sickness benefits by the invalidity institutes, the central government closely supervising all. None of these laws applied to all classes of people, but much space would be required to analyze and explain the details.

The system described was in operation in the German Empire before the First World War. An eminent authority stated before the Eighth International Congress of Actuaries in London in 1927, that, though the war had subjected the institutions to heavy strain and the postwar inflation has been a heavier load, the

system was substantially unchanged. Legislation has been enacted adapting it more closely to current governmental conditions and adding unemployment insurance.[1] The National Socialist government did not change the outward form of the system.[2] Its status at the present writing is unknown. It seems likely that on restoration of orderly government it will be rehabilitated.

The exact model of the German system has not been followed elsewhere, though Austria and Russia (before the Revolution) followed it quite closely.

Workmen's Compensation.—The principle of workmen's compensation may be said to have received world-wide acceptance, but with a most varied provision for insurance. As adopted in Great Britain, the employer is required to provide compensation but, with some exceptions, only his own self-interest is relied upon to compel insurance. At the other extreme lie the American states of Nevada, North Dakota, Oregon, Washington, and Wyoming, which have adopted the principle of compulsory insurance in a monopolisitc state fund.[3]

Sickness Insurance.—Compulsory sickness insurance has been introduced in many European countries, including Great Britain. Owing to the existence of the "friendly societies," corresponding roughly to our life-insurance fraternals, and their close association with the labor unions, the most complicated scheme of sickness insurance is that adopted in Great Britain in 1911. Contributions at rates specified in the act are required from the employer and the employee to cover seven-ninths of the cost, the government providing the remainder. The split between employer and employee varies with the wage, the employee at the lowest wage paying the largest percentage. The normal split is four-sevenths by the employee and three-sevenths by the employer. Contributions are collected through the employers, who must

[1] See Moldenhauer, Paul, "The Development and Basis of Social Insurance in Germany," *Transactions, 8th International Congress of Actuaries*, Vol. I, pp. 206–213.

[2] See Aurin, F., "Die Deutsche Sociolversicherungs," *Transactions, 10th International Congress of Actuaries* (Rome, 1934), Vol. IV, pp. 92–108.

[3] Only in Washington is such insurance compulsory or all employers subject to the act. In the other states the Industrial Commission may permit self-insurance.

buy stamps and attach them to the employees' cards. The employee is free to join any approved society but, if he is not accepted by one, he becomes a "deposit contributor" and is entitled to benefits from the post office to the extent provided by his own contributions, and by those made in his behalf by the government. As the rate of sickness varies with age, and selection is possible, actuarially determined present values are an essential part of the system, and elaborate accounting is necessary between the government and the societies in apportioning among them the government's contribution. As the societies select in part on the basis of occupation, some have much better experience than others, and are allowed to pay higher benefits.

Unemployment Insurance.—Concurrently with the introduction of sickness insurance, Great Britain adopted a system of unemployment insurance with an associated system of labor exchanges.[1] Postwar conditions placed severe strains upon the scheme, necessitating extensive assistance from government funds to cover the benefits, commonly and derisively called "doles." Since the war, compulsory unemployment insurance has been adopted in several other countries. Several have also provided subsidies for voluntary unemployment insurance schemes.[2] The British system is supported by contributions from workers, employers, and the government. It is administered by an elaborate form of cooperation between industrial associations and the government.

Old-age Pensions.—In 1908, Great Britain introduced a general system of old-age pensions provided by the government without an insurance system. Prior to that, New Zealand and Australia had introduced such systems, as had Denmark and several other countries. These pensions were thought of more as modifications of the systems of poor relief than a part of a social-

[1] The free labor exchange system was started in 1909, two years before unemployment insurance was introduced. This was partly to prepare the working machinery and partly to secure data for the unemployment-insurance plans.

[2] Studies and Reports of the International Labor Office, Series C (Employment and Unemployment)—No. 10, "Unemployment Insurance—Study of Comparative Legislation," p. 8.

Also "Unemployment Insurance," Monograph One, rev. ed. in a *Series on Social Insurance*, Metropolitan Life Insurance Co., February, 1935.

insurance system, but the provision of such benefits in Germany shows the close connection.

Despite the sketchiness of the above accounts, it will probably be apparent that the movement to apply the insurance principle to the problem of poverty as a matter of state policy has made rapid progress since its avowed introduction in Germany in the latter part of the last century. It will also be apparent that, except in Germany, the schemes were not introduced at one time, each as a part of a coordinated whole, but piecemeal as conditions emphasized the need, and the time seemed to be ripe. This method of introduction has resulted in varying, and sometimes quite inconsistent, systems of providing for insurance.[1]

Probably nowhere are the systems inclusive of the entire population. As each measure has been introduced, it has applied to a limited group and, by successive amendment, has been extended to larger numbers, and the benefits increased. In this respect the history of workmen's compensation in the United States is similar.

DEVELOPMENT OF SOCIAL INSURANCE IN THE UNITED STATES

Although farseeing American students of economic and social conditions have long been aware of the development of social insurance abroad and have urged its adoption here, progress has been slow and irregular,and achievement is yet far from complete.

Influence of the Form of Government.—No small factor in slowing up the adoption of such measures here has been the form of the government. It was generally held that the powers delegated to the federal government were not broad enough to include general provision of social insurance. So far as the power to do so existed it lay in the police powers of the several states. Even there the power was not undisputed. Several of the early workmen's compensation laws were held unconstitutional as violating provisions of federal and state constitutions, notably those forbidding the taking of property without

[1] An Inter-departmental Committee on Social Insurance and Allied Services was appointed by the British ministry in June, 1941 and recommended in November, 1942, a unified system. See "Social Insurance and Allied Services," report by Sir William Beveridge. Legislation along the lines recommended has been initiated in Parliament but not yet passed.

due process of law.[1] Later decisions have taken a broader point of view. Until the passage of the Social Security Act in 1935, federal legislation in this field had been confined to federal employees, employees in interstate commerce, maritime workers, and the District of Columbia, with some minor instances of grants in aid of state measures.[2]

Under these circumstances each measure has had to wait until the public attitude in an individual state has led its own legislature to adopt it. As the number of states adopting a particular policy (*e.g.*, workmen's compensation) has increased, the popular demand for similar legislation in other states has correspondingly increased and, for reasons to be later explained, the opposition has diminished. Furthermore, although provisions of earlier laws have influenced the form of statutes enacted by those states whose action came later, local considerations have led to many variations as to the amounts and conditions of benefits, the sources of funds from which they are to be paid, and administrative procedure.

Individualism.—The highly individualistic attitude of the American people is partly a cause of delay. Unless an unsatisfactory condition touches the individual in his personal affairs, he tends, unless he is something of a philanthropist, to ignore it. If a reform tends to restrict his freedom of action or to impose new burdens upon him, he is likely to oppose it. This is so even when he recognizes that the reform may benefit him if his present status remains fixed, for few have heretofore regarded their status as fixed. Nearly every person has regarded himself as a potential capitalist. Or, if he has given up hope of a higher status for himself, he still has believed the door for advance open to his children. He has been loath to take any action that might impede their advance. Furthermore, since some insurance of the type provided by social insurance is bought from private carriers by persons who would cease to carry it if it were provided otherwise, the insurance carriers and their agents have been found in

[1] See, *Ives v. So. Buffalo Ry. Co.*, 201 N.Y. 271 (1911).

[2] In a series of decisions in 1937 the Supreme Court upheld the constitutionality of the Social Security Act and in general the power of Congress to enact such legislation. In one case (*Helvering et al. v. Davis*, 301 U. S. 619) it rested the decision squarely on the General Welfare clause.

opposition. Even when private insurance has not entered a particular field, the fear that government activities might be extended beyond that field has led many connected with private insurance to oppose the "socialistic tendencies" of proposed legislation. When, however, intolerable conditions have been clearly brought home, action has sometimes been remarkably swift and far-reaching. The first workmen's compensation law to be held constitutional was not passed until 1911. In that year, 10 states adopted compensation acts. In the next 2 years 11 more were passed. By 1920, 45 states and territories had adopted the plan. Several of these laws provided for monopolistic state funds. There is now only one state without a workmen's compensation law.

Economic Competition among States a Retardant.—The several states differ in the extent of their natural resources and in the type and degree of industrial development. Despite the freedom of migration between states, they differ also in the dominant racial stocks and in the traditions and outlook of their populations. Some are notably progressive, and others are equally notable for their backwardness both in economic development and in social outlook. The more progressive states are leaders in the adoption of social legislation. But the regulation of commerce between the states is delegated by the Constitution to the federal government and, so far as the law can make it so, commerce between the states is free and unrestricted. The industries of each state are in free and open competition with similar industries in the other states, for both domestic and foreign markets. If burdens in the form of taxes or other regulations are imposed upon the industries of one jurisdiction in excess of those borne by competing industries domiciled elsewhere, the former are handicapped in the markets of the United States and other countries, even in the markets of their home state. Industrial interests have not been slow to bring this fact to the attention of legislators when new social legislation has been under consideration. It is strongly urged that leadership in such matters may be purchased at too high a price. There are even threats of removal of enterprises across state borders, though few if any cases can be found where such action was due solely to this reason. Counterarguments, based upon the probability

of greater efficiency of labor under better conditions, are advanced and sometimes accepted. But it is undoubtedly a fact that this factor of competition among the industrial interests of the several states has held back the leaders and retarded the development of social insurance throughout the country.

Agitation for Social-insurance Measures.—Study of social-insurance theory and practice by individuals and by government officials and bureaus started shortly after the European countries began adopting such laws. In 1891, the United States Bureau of Labor commissioned John Graham Brooks to make a study of the German system. In 1898, another study of social insurance was made at the request of the Massachusetts Legislature by the Bureau of Labor Statistics of that state. State commissions to study workmen's compensation for industrial accidents were appointed in Massachusetts in 1903, in Illinois in 1905, and in Connecticut in 1906. A notable step was taken in 1906 in the organization of the American Assocation for Labor Legislation which consistently sponsored workmen's compensation laws and drafted several model bills. A commission was appointed in 1907 in Massachusetts to study old-age pensions. It reported adversely in 1910. Agitation for public aid to mothers in order to provide home rather than institutional care for dependent children began as early as 1909, and measures to that end were repeatedly urged in the annual reports of the United States Children's Bureau.

The Twenty-third Annual Report of the Commissioner of Labor (1908), published in 1909, was a study of "Workmen's Insurance and Benefit Funds in the United States" and brought out their general inadequacy. The following Twenty-fourth Annual Report, published in 1911, was an extensive study in two volumes of "Workmen's Insurance and Compensation Systems in Europe."

At about the same time the Russell Sage Foundation undertook a survey of the conditions of the working population of Pittsburgh —the "Pittsburgh Survey"—published its findings in a series of volumes. One of these, "Work Accidents and the Law," by Crystal Eastman, published in 1910, gave great impetus to the movement to substitute the principle of workmen's compensation for that of employers' liability.

Three states appointed commissions to study workmen's compensation in 1909, six in 1910, and nine in 1911. These commissions held national conferences at which findings and drafts of laws were discussed. The drafts of the Wisconsin and first California laws, which were identical in terms, were considered at a meeting in St. Louis in 1910.

Beginning in 1915, commissions were appointed in several states to study old-age pensions, and the model bill of the American Association for Labor Legislation was introduced in 24 legislatures in 1923. It was passed by three. About the same time several states appointed commissions to study sickness insurance. Opposition from a variety of sources became so powerful that agitation for such measures was dropped during the decade of the 1920's and attention given to other aspects of the general problem.

A few labor unions had provided for unemployment benefits before 1920, but the numbers affected were not large. Also a few employers, notably the Dennison Manufacturing Company, whose industries had been subject to high seasonal fluctuations, had endeavored to stabilize employment and had established unemployment benefit schemes. The minor depression of the early 1920's gave some further impetus to this movement. The sudden plunge into the depression of the 1930's brought the problem of unemployment sharply to the fore and, despite the difficulties encountered by European systems, unemployment insurance was urged from many quarters.

In addition to the governmental and other organized investigations, several books were published during this period dealing with various phases of social insurance, and courses on the subject were introduced in the leading universities.

The movement culminated in the President's message to Congress of June 8, 1934, and his appointment shortly thereafter of his Committee on Economic Security. Following the report of that committee the Social Security Bill was introduced in Congress and became law in 1935.

Industrial Accidents and Disease and Workmen's Compensation Insurance.—The workmen's compensation principle has now been adopted in all states. In practically all of these insurance is required, but individual proof of financial responsibility is per-

mitted as an alternative. Nine states have set up competitive state funds. In the others the insurance is carried by private carriers. In no state is the entire working population under the act.[1]

Later, the problem of industrial disease, especially pneumonoconiosis, was much to the fore. The gradual and cumulative effect of exposure to harmful dusts and poisons is often permanent total disability and death. If the employee has not been working continuously for the same employer, it is clearly unfair to charge the entire cost of his disability to the last employer or his insurer. The problem is being met in different ways in the several states. There has been some suggestion that disability due to industrial diseases should not be covered under the compensation laws and that a separate scheme of insurance should be set up to cover them, but no plan for such action has come to the author's attention.

Federal legislation has been confined to the passage of compensation acts covering federal employees, private employees in the District of Columbia and the Panama Canal Zone, and harbor workers, not under the coverage of state acts. Employees in interstate commerce are still under the Federal Employers' Liability Act.

Sickness.—The federal government has not yet passed a general sickness-insurance act. The Committee on Economic Security recommended an increase in the appropriation for the federal Public Health Service and increased grants in aid of the state services. This recommendation was carried out in Title VI of the Social Security Act.[2] Respecting insurance the committee said,

> The committee's staff has made an extensive review of insurance against the risks of illness, including the experience which has accumulated in the United States and in other countries of the world. Based upon these studies the staff has prepared a tentative plan of insurance believed adequate for the needs of American citizens with small means and appropriate to existing conditions in the United States. From the very outset, however, our committee and its staff have recognized that the successful operation of any such plan will depend in large measure

[1] The general terms of these acts have been explained in Chap. XIII.

[2] Public Act No. 271—74th Congress.

upon the provision of sound relations between the insured population and the professional practitioners or institutions furnishing medical services under the insurance plan. We have accordingly submitted this tentative plan to our several professional advisory groups organized for this purpose. These advisory groups have requested an extension of time for the further consideration of these tentative proposals, and such an extension has been granted until March 1, 1935. In addition, arrangements have been effected for close cooperative study between the committee's technical staff and the technical experts of the American Medical Association.

Until the results of these further studies are available, we cannot present a specific plan of health insurance. It seems desirable, however, to advise the professions concerned and the general public of the main lines along which the studies are proceeding. These may be indicated by the following broad principles and general observations which appear to be fundamental to the design of a sound plan of health insurance.

1. The fundamental goals of health insurance are: (*a*) The provision of adequate health and medical services to the insured population and their families; (*b*) the development of a system whereby people are enabled to budget the costs of wage loss and of medical costs; (*c*) the assurance of reasonably adequate remuneration to medical practitioners and institutions; (*d*) the development under professional auspices of new incentives for improvement in the quality of medical services.

2. In the administration of the services the medical profession should be accorded responsibility for the control of professional personnel and procedures and for the maintenance and improvement of the quality of service; practitioners should have broad freedom to engage in insurance practice, to accept or reject patients, and to choose the procedure of remuneration for their services; insured persons should have freedom to choose their physicians and institutions; and the insurance plan shall recognize the continuance of the private practice of medicine and of the allied professions.

3. Health insurance should exclude commercial or other intermediary agents between the insured population and the professional agencies which serve them.

4. The insurance benefits must be considered in two broad classes: (*a*) Cash payments in partial replacement of wage-loss due to sickness and for maternity cases, and (*b*) health and medical services.

5. The administration of cash payments should be designed along the same general lines as for unemployment insurance and, so far as may be practical, should be linked with the administration of unemployment benefits.

6. The administration of health and medical services should be designed on a State-wide basis, under a Federal law of a permissive character. The administrative provisions should be adapted to agricultural and sparsely settled areas as well as to industrial sections, through the use of alternative procedures in raising the funds and furnishing the services.

7. The costs of cash payments to serve in partial replacement of wage loss are estimated as from 1 to 1¼ per cent of pay roll.

8. The cost of health and medical services, under health insurance, for the employed population with family earnings up to $3,000 a year, is not primarily a problem of finding new funds, but of budgeting present expenditures so that each family or worker carries an average risk rather than an uncertain risk. The population to be covered is accustomed to expend, on the average, about 4½ per cent of its income for medical care.

9. Existing health and medical services provided by public funds for certain diseases or for entire populations should be correlated with the services required under the contributory plan of health insurance.

10. Health and medical services for persons without income, now mainly provided by public funds, could be absorbed into a contributory insurance system through the payment by relief or other public agencies of adjusted contributions for these classes.

11. The role of the Federal Government is conceived to be principally (*a*) to establish minimum standards for health insurance practice, and (*b*) to provide subsidies, grants, or other financial aids or incentives to States which undertake the development of health insurance systems which meet the Federal standards.[1]

It is generally understood that the American Medical Association was officially opposed to the establishment of compulsory health insurance because of the fear of unsatisfactory terms of service and remuneration under a panel system. At the time the British health-insurance system was introduced, there was the same opposition from the medical profession, though it has since found itself uninjured. It is also understood that the committee feared that the opposition of the profession might endanger the passage of any act which included provisions for "socialized medicine."

[1] *Report to the President of the Committee on Economic Security*, Jan. 15, 1935, pp. 41–43. There has been no further report from the Committee on this subject, and the committee has been discharged. Its work is to be carried on by the Social Security Board. See Social Security Act, Sec. 702.

The author agrees in the main with the principles set forth in the committee's statement. Subdivision (*b*) of the first item implies that the entire cost of the system should be borne by the workers, and the eighth item indicates the belief that it is possible that workers can bear the entire cost. The author questions this when wages are so low that minimum-wage laws are deemed necessary.

He is also puzzled over the statement in the second item that "practitioners should have broad freedom . . . to choose the procedure of remuneration for their services." Its meaning is far from clear. In the light of the experience with the medical side of workmen's compensation which has made necessary the adoption of fee scales by the industrial commissions of most states, it seems impossible to leave to the practioners individually the determination of this point.

He does not know the source of the estimate of cost in the seventh item. As an actuary, it seems to him impossible to make a reasonable estimate without a clear knowledge of the amount and terms of cash benefit to be given, the extent of medical and kindred services to be rendered, and the scales of remuneration of the practitioner.

Rhode Island is the only state that has yet adopted a compulsory state sickness-insurance law. The act came into effect May 10, 1942, and benefit payments for sickness began Apr. 1, 1943. The act is administered by the state Unemployment Compensation Board[1] and is closely associated with the administration of unemployment compensation. It is supported by a tax on employees of 1 per cent of wages up to $3,000. The tax collected for the year previous to beginning of benefits was used to establish a fund to take care of fluctuations. The act provides for cash sickness benefits and thus avoids any controversy over state control of the relation of doctor and patient. There is a 1-week waiting period. Under the original act, in order to receive

[1] Rhode Island had an unemployment-compensation system which came into effect in 1936 and was supported by joint contributions of employers and employees, the employee's share being 1½ per cent, on all wages up to $3,000. It had accumulated a large surplus, and in 1942 it was proposed to eliminate the employee's contribution. As a compromise, two-thirds of the employee's contributions (1 per cent of wages) was diverted to establish the sickness fund.

benefit a worker had to show that he was "unable to perform any services for wages," but an amendment of Apr. 28, 1943 (28 days after benefit payment began), changed this condition to entitle the worker to benefit "when such sickness prevents him from being able to perform his regular services."

The act applies to workers in establishments employing four or more persons in each of 20 different weeks in a calendar year. It does not apply to workers in agriculture, domestic service, state or federal service, or in certain charitable and educational institutions.

The scale of benefits depends on the amount of wages earned during a 12-month base period immediately preceding the benefit year in which payments are claimed. The limits of total benefit payments permissible in any one year range from $34 on aggregate wages of $100 to $364.50 on wages of $1,800 or more. The time limit is 21 weeks. Normally the benefit is payable weekly, and the weekly rate of benefit is determined by the highest wages earned in one quarter of the base-year period. A weakness of the scheme is that the worker is permitted to collect benefits while drawing other payments, such as wages or salaries paid by employers during sickness, or workmen's-compensation benefits for accidental injuries.

The act is still in its experimental stage, but there are evidences of malingering and abuse due to double payment and vagueness of the law in certain respects, particularly the loose definition of sickness. Despite the large tax income during the high earnings of full war employment, the benefits paid for the 7-month period, April-October, 1944, exceeded the tax income by nearly $600,000. Critics of the scheme point out that it is not on an actuarial basis and that almost certainly the claims will rise and income fall when industrial activity slackens.

Proposals for similar laws have been presented in other states but none have yet been enacted.

Amendments to the federal Social Security Act which provide for both medical care and cash sickness benefits are pending in Congress.

Surviving Dependents.—The agitation already mentioned[1] had, by 1931, led to the passage of mothers' pension laws in

[1] See p. 557.

45 states. These were not insurance systems in the sense that contributions were required from those exposed to the risk or from others on their behalf in order to set up a fund from which to pay benefits. Nor were the rights to benefit limited to widows or those whose husbands had become invalids. Benefits on behalf of dependent children were provided also for deserted mothers, wives of convicted criminals, and other lone women unable otherwise to care for their dependent children. The benefits were provided from general state and county funds. The administration was generally assigned to welfare departments.

During the depression many of the states found themselves unable to carry through their programs, and the Committee on Economic Security recommended "that the Federal Government give assistance to States in providing local services for the protection and care of homeless, neglected and delinquent children and for child and maternal health services especially in rural areas."[1] Titles IV and V of the Social Security Act carry out this recommendation. Under Title IV each state whose plan for aid to dependent children meets certain standards is given federal aid to the extent of one-half of the total sums expended "not counting so much of such expenditure with respect to any dependent child for any month as exceeds $18, or if there is more than one dependent child in the same home, as exceeds $18 for any month with respect to one such dependent child and $12 for such month with respect to each of the other dependent children."[2]

Other than in such legislation, in the death benefits under workmen's compensation laws and in the pension provisions noted hereafter, there is no system of survivors' benefits in effect.

Old-age Benefits.—Beginning with Alaska in 1915, 28 states and two territories had passed some sort of old-age-pension law by 1934. These laws all provide for noncontributory pension plans. Pensioners are subject to a "means test," though eligibility requirements vary considerably. In many states much of the cost was put on local communities. Since these were overburdened with other relief and financial problems during the depression, the administration tended to be strict, and the

[1] *Op. cit.*, p. 6.
[2] Sec. 403 (a).

schemes were ineffective. In no state was there any other form of general pension benefit, though some had carefully organized retirement systems for public employees.

Old-age Provisions of the Social-security Act.—Such was the situation at the time of the appointment of the Committee on Economic Security. That committee gave much attention to the problem of old-age security and recommended two different types of measures:

1. A contributory plan for workers employed in certain industries, with the cost of the benefits met by equal contributions from employees and employers, to be administered by the federal government.
2. Aid to state pension plans, to cover those not coming under the first plan.[1]

The two recommendations were, in principle, embodied in the Social Security Act.

Old-age Assistance.—The second recommendation dealt with the more immediate and pressing problem, did not present the difficult constitutional question involved in the first, and did not require the elaborate machinery called for by the first. It was embodied in the Social Security Act as "old-age assistance" to take effect retroactively as of July 1, 1935.[2] $49,750,000 was appropriated for the fiscal year ending June 30, 1936, and authorization given for appropriation in each subsequent fiscal year of a sum sufficient to carry out the purposes of the act.[3] The sums made available were to be "used for making payments to States which have submitted, and had approved by the Social Security Board,[4] . . . . . State plans for old-age assistance."[5]

Standards for approval are set up in the act, as amended in 1939, as follows:

Sec. 2. (*a*) A State plan for old-age assistance must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for finan-

[1] *Op. cit.*, pp. 25 and 26.

[2] Social Security Act, Title I.

[3] *Ibid.*, Sec. 1.

[4] The Act sets up a Social Security Board of three members to have general administrative duties under the act and to be appointed by the President by and with the advice and consent of the Senate.

[5] Social Security Act, Sec. 1.

cial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide for granting to any individual, whose claim for old-age assistance is denied, an opportunity for a fair hearing before such State agency; (5) provide such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Board shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Board to be necessary for the proper and efficient operation of the plan; (6) provide that the State agency will make such reports, in such form and containing such information, as the Board may from time to time require, and comply with such provisions as the Board may from time to time find necessary to assure the correctness and verification of such reports; and (7) effective July 1, 1941, provide that the state agency shall, in determining need, take into consideration any other income and resource of an individual claiming old-age assistance; and (8) effective July 1, 1941, provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of old-age assistance.

(*b*) The Board shall approve any plan which fulfills the conditions specified in subsection (*a*), except that it shall not approve any plan which imposes, as a condition of eligibility for old-age assistance under the plan—

(1) an age requirement of more than sixty-five years, except that the plan may impose, effective until January 1, 1940, an age requirement of as much as seventy years; or

(2) Any residence requirement which excludes any resident of the state who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application; or

(3) Any citizenship requirement which excludes any citizen of the United States.

The Board is required to withdraw approval, after notice and hearing, if the state plan is so changed or its administration so conducted, that it no longer meets these standards.[1]

[1] Sec. 4.

The federal aid, payable to the states quarterly, is one-half of the total of the sums expended for old-age benefits to persons sixty-five years of age and older not inmates of public institutions, excluding the excess over $40 per month paid to any individual, plus 5 per cent for administrative expense.[1]

The states are free to apply a "means test" and the phraseology quoted implies that it is expected that such a test will be applied. Moreover, the benefit is not fixed except that the federal contribution shall not exceed the maximum set. The scheme is, therefore, one of "outdoor aid" whose cost is shared by state and national governments rather than a true free pension or insurance provision.

Old-age and Survivors' Benefits.—The first recommendation (as respects the benefits and the funds from which they are paid) of the Committee on Economic Security is embodied in Title II, "Federal Old-Age and Survivors Insurance Benefits," of the act as amended in 1939. As the act was originally passed it contained a tax measure in Title VIII. When the act was amended in 1939, this was deleted and the Internal Revenue Code was amended by inserting the taxing provisions as Subchapter A of Chap. 9. The act itself indicated no connection between these titles and left it to each succeeding Congress to make the necessary appropriations. This apparently illogical separation was made on the advice of constitutional lawyers in the hope of avoiding a successful attack upon the constitutionality of the act.[2] The taxes applied on and after Jan. 1, 1937, but no benefits became payable before Jan. 1, 1940.

All employees are brought under these provisions except

1. Agricultural laborers.
2. Domestic servants in a private home, local college club, fraternity, or sorority.
3. Casual laborers, not in the course of the employer's trade or business.
4. Persons working for their spouses or children and children under twenty-one working for their parents.

[1] Sec. 3 (*a*).

[2] The act as a whole and its tax provisions as a whole were sustained in a series of cases before the U. S. Supreme Court: *Carmichael v. Southern Coal and Coke Co.*, 301 U. S. 495 (1937), *Steward Machine Co. v. Davis*, 301 U. S. 548 (1937), and *Helvering, Commissioner of Internal Revenue, et al. v. Davis*, 301 U. S. 619.

5. Officers and members of the crew of a legally documented non-American vessel.

6. Employees of the United States government or, with certain limitations, an instrumentality of the United States government.

7. Employees of a state, a political subdivision thereof or, with certain limitations, an instrumentality of either.

8. Employees of nonprofit-making institutions, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals.[1]

The self-employed in trade and those engaged in the independent practice of a profession are not covered. These, with the first two classes of exclusions, constitute a considerable part of the working population. If they are not able to accumulate a fund for their own old age, their only relief under the act lies in old-age assistance.

The benefits provided are of seven classes:

1. Old-age benefits beginning at age sixty-five and continuing for life, with the proviso that during any month in which a beneficiary receives wages of $15 or more for regular employment after reaching age sixty-five he shall receive no benefit.[2]

2. Wife's insurance benefits available to the wife of a person entitled to old-age benefits if she has attained the age of sixty-five, is living with her husband, and is not entitled to benefits in her own right as an insured person equal to one-half the benefit to which her spouse is entitled. The amount of the wife's benefit is the excess, if any, of one-half the husband's benefit over her own rights and continues for life or until the death of her husband, but terminates if a divorce should take place.

3. Child's insurance benefits available to children under eighteen years of age if dependent on a person entitled to old-age benefits or, in case the person has died, if the child was dependent at the time of his death. The benefit continues until age eighteen, unless prior thereto the child dies, is adopted, or marries. The child's benefit is one-half the benefit of the person with respect to whose wages it is entitled to benefit and, if there is more than one such person, it is one-half of whichever of the primary benefits is greatest.

[1] See Sec. 209 (b) and Sec. 1426 (b), I. R. Code.

[2] Sec. 203 (d).

4. Widow's insurance benefits, equal to three-fourths of her deceased husband's benefit rights, available to the widow of a person who was fully insured at his death (after Dec. 31, 1939), who was living with him at the time of his death, has not remarried, has attained the age of sixty-five years, and is not entitled to benefits in her own right. The amount of the widow's benefit, if she is entitled to benefits in her own right, is the excess, if any, of three-fourths of her late spouse's benefit over her own rights and continues for life or until remarriage.

5. Widow's current insurance benefits, available to the widow of a fully or currently[1] insured person, if she was not entitled to benefits under the preceding item, was living with her husband at the time of his death, has not remarried, and has in her care a child of the deceased entitled to a child's benefit. The amount of the benefit is the excess, if any, of three-fourths of the old-age benefit to which the deceased would be entitled under the old-age-benefit formula over her own presently available rights and continues so long as she has in her care a child of the deceased entitled to a child's benefit (normally until the child is eighteen) or she dies or remarries.

6. Parent's insurance benefits, available to a parent of a person who died a fully insured person after Dec. 31, 1939, if the parent was wholly dependent upon and supported by the deceased at the time of death, has attained the age of sixty-five, and has not remarried. The amount of the benefit is the excess, if any, of one-half the old-age benefit to which the deceased would be entitled under the old-age-benefit formula over any other insurance benefit the parent may be entitled to under the act. When there is more than one individual with respect to whose wages the parent is entitled to make a claim, the parent's benefit is based on the largest.

7. Lump-sum death benefits. If on the death of a fully or currently insured individual there be no widow's, child's, or

[1] A "fully insured" person is one who has contributed and had coverage for at least half the quarters since 1936, or since he became twenty-one if later, and up to age sixty-five or the time of his death, and in no case less than six quarters or, in any case, if he has had coverage for at least 40 quarters. A "currently insured" person is one who has been paid taxable wages of at least $50 for each of not less than six of the 12 quarters immediately preceding the quarter in which he died.

parent's benefits payable, six times the insured's primary benefit is payable in a lump sum to surviving relatives in a specified order of precedence or, if there be no such relative surviving, to any person or persons equitably entitled thereto, to the extent and in the proportions that he or they have paid for the expenses of burial of the deceased.

These benefits are payable monthly. The old-age benefit, to which the others are related, is termed in the act the "primary insurance benefit." It is defined by the act by a formula as follows:

(1) (A) 40 per centum of the amount of an individual's average wage if such average monthly wage does not exceed $50, or (B) if such average monthly wage exceeds $50, 40 per centum of $50, plus 10 per centum of the amount by which such average monthly wage exceeds $50 and does not exceed $250, and

(2) an amount equal to 1 per centum of the amount computed under paragraph (1) multiplied by the number of years in which $200 or more of wages were paid to such individual. Where the primary insurance benefit thus computed is less than $10, such benefit shall be $10.[1]

Under this formula the benefit of a covered employee, whose average monthly wage is $100 and who has been covered by the act for 10 years, is computed as follows:

40 per cent of $50 (the first $50 earned)	$20.00
10 per cent of $50 (excess of wages over the first $50)	5.00
Basic amount	$25.00
$25 multiplied by 1 per cent times 10 (years of coverage)	2.50
Primary old-age insurance benefit	$27.50

The taxes to provide the benefit are levied equally on employer and employee and at present are 1 per cent of wages (up to $3,000) from each, a total of 2 per cent.[2]

[1] Sec. 209 (c). The original Act had a different formula which gave less for shorter duration of work and lower earnings and advanced more rapidly. The present formula was set up in the amendments adopted in 1939. The original act provided that no benefits were to be payable until Jan. 1, 1942. The same set of amendments provided that benefits become available Jan. 1, 1940.

[2] The original act levied taxes beginning at 1 per cent each on wages of 1936 and contemplated an increase of ½ per cent each every 3 years until a total of 3 per cent each (the ultimate rate) was reached in 1949. The

In the original act the collection of taxes was provided for in Title VIII. They were to be placed in the Treasury and annually appropriated by Congress to the Old-age Reserve Account. In April, 1939, after the act had been sustained by the Supreme Court, the taxing provisions were by act of Congress transferred to the Internal Revenue Code, and in the Social Security Act Amendments of 1939,[1] Congress appropriated the entire amount of the Old-age Reserve Account and 100 per cent of the future tax collections to the Federal Old-age and Survivors' Insurance Trust Fund. This fund is administered by a Board of Trustees consisting of the Secretary of the Treasury (managing trustee), the Secretary of Labor, and the Chairman of the Social Security Board, all ex officio. The Trust Fund is wholly dedicated to the payment of the Old-age and Survivors' Insurance Benefits. The tax is to be regarded, as respects collection, as internal revenue and may be collected as the Treasury sees fit. The use of stamps sold through the post office is specifically permitted.[2]

The terms of the original act clearly indicated an intent to handle the finance along the lines followed by legal-reserve life-insurance companies, with the accumulation of corresponding reserves the amount of which were to be invested in special government securities issued by the Treasury for that purpose. The adoption of this plan created a widespread and heated controversy, a full review of which is not necessary here, which led to the appointment in May, 1937, of an Advisory Council on Social Security which reported on Dec. 10, 1938. Its recommendations were under three heads:

1. Recommendations on benefits.
2. Recommendations on coverage.
3. Recommendations on finance.

Since the controversy which led to the appointment of the Council was over the large accumulation in reserve which the scales of benefits and taxation would bring about, the question

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taxes were frozen in 1939 before the first increase came into effect but left the rate for 1942 and subsequent years as originally provided. Before the increase for 1942 and 1945 came into effect the rate was frozen in each case to continue at 1 per cent.

[1] H. R. 6635, approved Aug. 10, 1939.

[2] Internal Revenue Code Sec. 1423.

of full reserve, partial reserve, or pay as you go bulked large in its deliberations.[1] Although the recommendations on benefits were believed to produce a better type of benefit than were found in the existing law, it was recognized that beginning payments sooner and increasing the benefits for lower wage scales and shorter period of earnings under the Act would slow down the accumulation of the reserve. It was also recognized that larger and earlier benefits under Old-age and Survivors' Insurance would tend to reduce the burden under the Old-Age-Assistance provisions.

The amendments made in the benefits in 1939 substantially carried out the Council's recommendations on this topic. There is, therefore, no point in listing them.

Many of those who advocated making the old-age-insurance system self-supporting, with the associated large reserve, argued strongly that, since that system excluded large classes of the population, it was inequitable to provide a considerable part of the benefits from general revenue raised in part by taxation of those who could not become beneficiaries. This had some influence on the Council's discussion of coverage, but its recommendations on coverage were mainly based on what it considered best for the country as a whole. Most of the limitations on coverage of the original act were for technical reasons, some legal[2] and some practical.[3]

The Council recommended that employees of private nonprofit religious, charitable, and educational institutions be immediately brought under the act, that the coverage be extended to farm employees and domestic employees by Jan. 1, 1940, if administratively possible, that as soon as feasible the program be extended to include additional groups,[4] and that studies of the administrative, legal, and financial problems involved to be made in the interim.

It was not found feasible fully to carry out these recommenda-

[1] The author was a member of the Council and can speak with authority on this point.

[2] *E.g.*, the question whether taxation of religious institutions as employers might conflict with the guarantee of religious freedom, whether the states could be taxed as employers, etc.

[3] *E.g.*, the difficulty of collecting taxes for farm employees, the existence of federal and state employees' retirement systems, etc.

[4] *E.g.*, the self-employed.

tions when the amendments of 1939 were made, though there were some changes in classification and broadening of coverage. The matter has been under consideration since, though handicapped by national concentration on the war, and efforts are now being made to find practical ways of including additional classes, particularly farm and domestic employees.

The recommendations on finance were as follows:

I. Since the nation as a whole, independent of the beneficiaries of the system, will derive a benefit from the old-age security program, it is appropriate that there be Federal financial participation in the old-age insurance system by means of revenues derived from sources other than payroll taxes.

II. The principle of distributing the eventual cost of the old-age insurance system by means of approximately equal contributions by employers, employees, and the government is sound and should be definitely set forth in the law when tax provisions are amended.

III. The introduction of a definite program of Federal financial participation in the system will affect the consideration of the future rates of taxes on employers and employees and their relation to future benefit payments.

IV. The financial program of the system should embody provision for a reasonable contingency fund to insure the ready payment of benefits at all times and to avoid abrupt changes in tax and contribution rates.

V. The planning of the old-age insurance program must take full account of the fact that, while disbursements for benefits are relatively small in the early years of the program, far larger total disbursements are inevitable in the future. No benefits should be promised or implied which cannot be safely financed not only in the early years of the program but when workers now young will be old.

VI. Sound presentation of the government's financial position requires full recognition of the obligations implied in the entire old-age security program and treasury reports should annually estimate the load of future benefits and the probable product of the associated tax program.

VII. The receipts of the taxes levied in Title VIII of the law, less the costs of collection, should through permanent appropriation be credited automatically to an old-age insurance fund and not to the general fund for later appropriation to the account, in whole or in part, as Congress may see fit. It is believed that such an arrangement will be constitutional.

VIII. The old-age insurance fund should specifically be made a trust fund, with designated trustees acting on the behalf of the prospective beneficiaries of the program. The trust fund should be dedicated exclusively to the payment of the benefits provided under the program and, in limited part, to the costs necessary to the administration of the program.

IX. The consideration of change in the tax schedule under Title VIII of the law should be postponed until after the rates of 1½ per cent each on employer and employee are in effect since information will not be available for some time concerning (a) tax collections under varying conditions, (b) effective coverage under taxes and benefits, (c) average, covered earnings, period of coverage, time of retirement, and average amount of benefits, (d) the possibilities of covering farm labor, domestic employees or self-employed persons, and (e) the possibilities of introducing new types of benefits.

X. The problem of the timing of the contributions by the government, taking into account the changing balance between payroll tax income and benefit disbursements, is of such importance as to require thorough study as information is available.

XI. Following the accumulation of such information, this problem should be restudied for report not later than January 1, 1942, as to the proper planning of the program of payroll taxes and governmental contributions to the old-age insurance system thereafter, since by that time experience on the basis of five years of tax collections and two years of benefit payments (provided the present Act is amended to that effect) will be available. Similar studies should be made at regular intervals following 1942.

Some interpret these recommendations as advocating a pay-as-you-go system of finance. The author, who assisted in drafting them, did not, and does not now, so interpret them. When the report came before Congress with a draft of amendments in 1939, some members of the Council as individuals appeared before the committees and advocated that the tax rates be frozen at 1 per cent, which was done. When the next increase due Jan. 1, 1943, was impending, the rates were again frozen at 1 per cent, but it should be noted that these actions were only suspensions of the specific increase and that there was no general rearrangement of the tax scheme. The actions were recognized as temporary measures pending further study of the whole problem.

The author interprets these recommendations as advocating a

flexible program of financing. He calls particular attention to items III, V, VI, X, and XI. The benefits under the act are not, like the face amount of a life-insurance policy or the annual payments under an annuity sold by a life-insurance company, fixed amounts whose present value may be estimated with relative precision by the use of mortality and interest tables, nor is the tax in respect to any beneficiary a fixed annual sum like life-insurance premiums whose present value may be similarly estimated. The benefits, though fixed by formula, depend upon earnings of individuals under economic conditions whose variations are highly unpredictable and, even were there no power in Congress to change tax rates, the pay rolls to which the taxes apply are economic variables of high variation. Hence rigid schemes of financing cannot be depended upon to work out safely and guarantee that the obligation will be met when due. The problem is much like that of navigating a ship without the benefit of radio direction. A course may be laid out at the start of the voyage on the basis of anticipated conditions, but observations to determine the position of the ship must be taken at intervals, and such alteration in the course as those observations indicate to be necessary must be made promptly if the voyage is to be successfully completed.

The recommendations recognize these conditions. The idea of relying only on the joint contributions is definitely repudiated in the first two recommendations, and the tripartite responsibility of industry, of the nation, and of the prospective beneficiaries is recognized as justified by direct or indirect gain to each from the program. It was not overlooked that the form and timing of the required taxation will have important repercussions on the whole national economy. It is pointed out that the required cash disbursements will be increasing in amount for many years until the plan has well matured and that, unless some advance provision is made, the ultimate load may be such that the system will break down. Hence the best possible estimates of the ultimate load should always be used as a guide in financing it.

Although the recommendations did not present a specific plan for the observation of the course in relation to the goal, a memorandum was presented too late for formal consideration which did

outline such a plan and which was studied by the Social Security Board. It may be that the requirement in Sec. 201 (b), as amended that the annual report of the trustees of the Trust fund contain "a statement of the actuarial status of the Trust Fund," was inspired by that memorandum and was intended as a means of keeping Congress and the nation informed for the purpose of making needed adjustments in the financial provisions. The amendment setting up the Federal Old-age and Survivors' Insurance Trust Fund and the Board of Trustees[1] appears to have been in direct response to recommendations VII and VIII. Section 201 (b) now contains the following provision:

> It shall be the duty of the Board of Trustees to
>
> (1) Hold the Trust Fund;
>
> (2) Report to the Congress on the first day of each regular session of the Congress on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the next ensuing five fiscal years;
>
> (3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that during the ensuing five fiscal years the Trust Fund will exceed three times the highest annual expenditures anticipated during that five-fiscal-year period, and whenever the Board of Trustees is of the opinion that the amount of the Trust Fund is unduly small.
>
> The report provided for in paragraph (2) above shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected future income to and disbursements to be made from, the Trust Fund during each of the next ensuing five fiscal years, and a statement of the actuarial status of the Trust Fund.

These requirements appear to be an attempt to adopt the principles just discussed. The exigencies of the threat of war and consequent rearmament in 1940 and 1941 prevented the restudy recommended in item XI. Shortly after V-E day Congress provided for an expert study of this financial problem and made an appropriation for its support. In the meantime bills have been considered by Congress greatly extending the scope of the act, in particular including coverage of disability, both permanent and temporary. None has yet passed, but a measure

[1] See p. 571.

of this type is now before Congress which also provides for much higher taxation.[1] The fourth and fifth reports of the trustees have now been made and clearly indicate the need of flexible financial provisions. The effect of wartime conditions on wage rates, pay rolls, and employment possibilities apparently led many beneficiaries to postpone retirement and greatly increased the yield of the pay-roll taxes. The trustees, in estimating the immediate and long-range future obligations and resources, felt constrained to present two sets of estimates based on different assumptions as to postwar economic readjustments. Of course, the introduction of disability benefits will materially increase the cost, and the expert study will undoubtedly take this into account. What amendments may follow from it cannot now be predicted.

Shortly before the passage of the Social Security Act a separate Railroad Retirement Act was passed with a different scheme of benefits and finance. Recently proposals have been presented to Congress for liberalizing this act. This has raised the question of the social policy of special acts for groups of workers who for various reasons are able to bring pressure to bear.[2]

Unemployment.—Wisconsin passed a compulsory unemployment-insurance law in 1932 to go into effect July 1, 1933, but the effective date was postponed to July 1, 1934. This was the only unemployment-insurance law in effect in the United States prior to the passage of the Social Security Act, though many state legislatures had considered bills to provide for unemployment insurance. The Wisconsin law provided for individual plant reserves. The bills introduced in the other states provided mainly for pooled funds for the entire state or, at least, pooled funds for each industry. There has been much controversy over the relative desirability of the different types. Referring to this controversy the Committee on Economic Security said:

> In this country there has been considerable interest in unemployment insurance ever since the enactment of the pioneer British law of 1911, especially since the depression of 1920–21. In the years that have intervened considerable controversy has developed over the type of unemployment compensation legislation that should be enacted; particularly over such questions as unemployment insurance versus unem-

[1] Senate bill 1050, 79th Congress, 1st Session, May 24, 1945.

[2] See ROBBINS, RAINARD B., "Railroad Social Insurance."

ployment reserves, employee contributions, governmental contributions, extended benefits, and the type of unemployment to be benefitted. It is our conviction that these controversies have developed largely because there has been no action, and, therefore, no practical experience on this subject. Further investigations and other devices for delay will merely enhance the negative character of the debate. What is needed at this stage is demonstration, not further debate and research.

This background, it seems to us, is an important consideration in determining the type of unemployment compensation legislation to be recommended. It clearly suggested the desirability of permitting considerable variation, so that we may learn through demonstration what is best. This, we believe, can at this time best be secured under a cooperative Federal-State system, which permits variations in State laws but insures uniformity in respects in which uniformity is absolutely essential.[1]

In accordance with this recommendation, the provision for unemployment compensation in the Social Security Act is by way of grants in aid to states for assistance in the administration of their unemployment-compensation laws and by way of abatement of federal taxes levied upon employers in such states, provided their laws are approved by the Social Security Board.

Title IX of the Social Security Act levied excise taxes upon all employers of eight or more in the following percentages of the total wages payable by them; in 1936, 1 per cent; in 1937, 2 per cent; in 1938 and thereafter, 3 per cent. The taxpayer may credit against this tax the amounts paid into an unemployment fund under a state law up to a limit of 90 per cent of the federal tax, provided the state law has been approved by the Social Security Board.[2]

In 1939 the taxing provisions of Title IX were repealed, and the unemployment tax is now provided for by Secs. 1600–1611 of the Internal Revenue Code. The tax is continued at 3 per cent with the same provision for credit for payment into a state fund.

Standards are now set up for the approval of state plans as follows:

The Social Security Board shall approve any State law submitted to it, within thirty days of such submission, which it finds provides that:

[1] *Report of the Committee on Economic Security*, p. 15.

[2] Secs. 901 and 902.

(1) All compensation is to be paid through public employment offices or such other agencies as the Board may approve;

(2) No compensation shall be payable with respect to any day of unemployment occurring within two years after the first day of the first period with respect to which contributions are required;

(3) All money received in the unemployment fund shall [except for refunds of sums erroneously paid into such fund and except for refunds paid in accordance with the provisions of section 1606 (b)] immediately upon such receipt be paid over to the Secretary of the Treasury to the credit of the Unemployment Trust Fund established by section 904;

(4) All money withdrawn from the unemployment fund of the State shall be used solely in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such funds and refunds paid in accordance with the provisions of section 1606 (b);

(5) Compensation shall not be denied in such State to any otherwise eligible individual for refusing to accept new work under any of the following conditions: (A) if the position offered is vacant due directly to a strike, lockout, or other labor dispute; (B) if the wages, hours, or other conditions of the work offered are substantially less favorable to the individual than those prevailing for similar work in the locality; (C) if as a condition of being employed the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization;

(6) All the rights, privileges, or immunities conferred by such law or by acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal such law at any time.

The Board shall, upon approving such law, notify the Governor of the State of its approval.[1]

Provision is made for experience rating under state plans, for guaranteed employment accounts, and for individual-employer reserve funds. Employers are permitted to deduct from their tax in any taxable year after 1937, in addition to what they pay into a state fund, the amount by which they are permitted to reduce their contribution to the State Fund because of either favorable experience or their maintenance of an establishment fund or employment-guarantee fund, up to the total limit of 90 per cent.[2]

[1] Secs. 1603 (a) and (b). The refund provisions of Sec. 1606(b) relate to payments of federal instrumentalities into a state fund which is later not approved by the Board.

[2] I.R.C. Secs. 1601, 1602.

Employment in the following classes is not within the scope of the unemployment-compensation provisions:

1. Agricultural labor.
2. Domestic service in a private home, local college club, or local chapter of a college fraternity or sorority.
3. Casual labor not in the course of the employer's trade or business.
4. Service as an officer or member of the crew of a vessel on navigable waters of the United States.
5. Employment by son, daughter, or spouse, or employment of children under twenty-one by either parent.
6. Employment by the United States government or wholly owned instrumentality of the United States, or one exempted by law.
7. Employment by a state, political subdivision thereof, or an instrumentality of either which is wholly owned or otherwise exempt from federal taxation.
8. Employment by nonprofit-making institutions, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals.[1]

Since not more than 90 per cent of the tax may be deducted, the remainder goes to the federal government impliedly for the expense of administration. Eighty million dollars is to be appropriated for each fiscal year after June 30, 1938, and is to be apportioned among the states to assist in meeting the expenses of administration of their laws. This amount is to be apportioned by the Social Security Board on the basis of population, the number of persons covered by the state law, the cost of its proper administration, and such other factors as the Board finds relevant.[2] No payment may be made to a state unless its law has been approved and includes provision for

(1) Such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Board shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Board to be reasonably calculated to insure full payment of unemployment compensation when due; and

(2) Payment of unemployment compensation solely through public employment offices or such other agencies as the Board may approve; and

[1] I.R.C. Sec. 1607 (c).
[2] Title III. Secs. 301 and 302.

(3) Opportunity for a fair hearing, before an impartial tribunal for all individuals whose claims for unemployment compensation are denied; and

(4) The payment of all money received in the unemployment fund of such State (except . . .)[1] immediately upon such receipt, to the Secretary of the Treasury to the credit of the Unemployment Trust Fund established by section 904; and

(5) Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation, exclusive of expenses of administration; and for refunds . . .,[1] and

(6) The making of such reports in such form and containing such information, as the Board may from time to time require, and compliance with such provisions as the Board may from time to time find necessary to assure the correctness and verification of such reports; and

(7) Making available upon request to any agency of the United States charged with the administration of public works or assistance through public employment, the name, address, ordinary occupation and employment status of each recipient of unemployment compensation, and a statement of such recipient's rights to further compensation under such law; and

(8) Effective July 1, 1941, the expenditure of all moneys received pursuant to section 302 of the title solely for the purposes and in the amounts found necessary by the Board for the proper and efficient administration of such State Law; and

(9) Effective July 1, 1941, the replacement, within a reasonable time, of any moneys received pursuant to section 302 of this title, which, because of any action or contingency have been lost or have been expended for purposes other than, or in amounts in excess of, those found necessary by the Board for the proper administration of such State Law.[2]

Several purposes are implicit in these standards:

1. It is intended to give the states wide freedom in setting up their unemployment insurance systems, but

2. It is intended to require conformity to minimum standards.

3. No state is to be in a position to gain a competitive advantage over others by setting up no law, or a less costly law, since its employers must pay the tax in any event and, if it does not act, its workers get no benefits.

[1] The refunds here excepted are the same as in the Standards for Approval.

[2] Sec. 303 (a).

4. The investment of the funds is to be in the hands of the federal authorities.[1]

The Social Security Board has approved the acts of the 48 states, the territories of Alaska and Hawaii, and the District of Columbia. The general plan of the California Act, which was first passed in 1935 and which met approval, in its present amended form, is fairly typical.

The employments brought under the California Act are the same as under the federal act, but the act now applies to employers having four or more employees.

The employers' contributions are to be at 90 per cent of the taxes levied by the federal act with power in the state Commission set up by the act to recommend to the legislature a higher rate for any class of industry or of occupation in which unemployment is excessive or chronic. There is a provision for merit rating which took effect in 1941 by which the employer's contribution rate may be reduced to not less than 1 per cent of wages but, if the funds on hand in this trust fund fall below one and one-half times the amount of the benefits paid during the preceding calendar year, the commission may by appropriate notice require all employers to pay the full rate of tax.

Employees were required to contribute one-half of 1 per cent of wages in 1936, and, beginning in 1937, 1 per cent, but their rate of contribution is not to exceed 50 per cent of that of their employer.

Benefits first became payable after Jan. 1, 1938, for unemployment occurring after that date. To qualify for benefits the employee must give suitable notice to the Commission, register for work, thereafter continue to report at a public employment agency or other place approved by the Commission, be able to work and available for work, and have been unemployed for a waiting period of 2 weeks, which need not be consecutive.

He is not eligible for benefits for a week in which he left his most recent work voluntarily without good cause nor for the immediately following week. Nor is he eligible for a week in

[1] Some economists feel that wise use of the unemployment reserves in controlling the national fund of credit may be highly effective in reducing the swing of business cycles and be more beneficial than the actual disbursement of unemployment benefits.

which he has been discharged for misconduct, and in the discretion of the Commission for not more than the 5 following weeks, depending on the finding of the Commission as to the seriousness of the misconduct. Benefit is denied him if he left his work because of a trade dispute, for the period during which he continues out of work by reason of the fact that the trade dispute is still in active progress in the establishment in which he was employed. It is also denied if, without good cause, he has refused to accept suitable employment when offered, or failed to apply for suitable employment when notified by the district employment office. To be suitable, the employment must offer wages, hours, and other conditions as favorable as those prevailing in the locality for similar work, must not force him to become a strikebreaker, to forfeit his union standing or to join a company union, and must not endanger his health, safety, or morals more than his regular employment, nor tend to diminish his skill and training.

The weekly benefit ranges from $10 to $20 and is based on the amount of wages earned in the highest quarter of the "base period," roughly the year preceding the claim. The benefit is set forth in a schedule in the act and is one-twentieth of the quarter's earnings, taking the fraction to the next highest even dollar. No more may be claimed in one year than sixteen times the weekly benefit.

Whenever the Commission determines that, in view of existing or probable future conditions, the fund will, within 6 months, be insufficient to pay probable benefit liabilities in full, it may reduce or discontinue all benefits.

The State Treasurer is made custodian of the funds but is required to deposit them in the "unemployment trust fund" of the United States government, as required by the federal act [1]

Unemployment is unlike the other risks dealt with in this book, those covered by either private or social insurance, in its unpredictability. It does not appear to fluctuate around an average or to show slow gradual change like the rate of mortality. More-

[1] A list of states which have enacted unemployment insurance laws and a digest of their provisions may be found in the latest report of the Social Security Board or in the *Monthly Labor Review*.

over, it is essentially a catastrophic risk which cannot be handled through line limits and reinsurance as is the risk of conflagration in fire insurance. A reflection of this is found in the provision of the California act permitting the Commission to reduce or suspend benefits if it appears that the funds cannot stand the strain of full benefit. To many, the term "insurance" is not properly applicable to the schemes to meet it. It is, at best, a palliative, piling up funds in prosperous times for disbursement in benefits during times of unemployment. Few who have studied the problem believe that any such scheme can carry the full load of a major depression. It is for this reason that the limitations in the benefits have been inserted. It will undoubtedly be necessary for the government to provide relief for those whose benefit rights are exhausted by public works or otherwise. Such has been the experience in Great Britain and other European countries which have included unemployment benefits in their social-insurance systems. This statement is not to be taken as condemnation of the effort. The temporary and limited benefit may well assist the worker thrown out by depression or by a new invention to carry himself over a period of adjustment to new conditions that will be of great advantage not only to him but to the whole country. Perhaps, if the funds collected are properly handled, so as not to stimulate creation of new capital goods, the brake placed upon expansion in prosperous times through the taxes imposed and the disbursement of funds in benefits during depression may do much to iron out industrial fluctuations.

Because of these considerations some economists are becoming concerned over the tendency now prevalent in nearly all states to extend merit or experience rating to unemployment insurance.[1] It tends to reduce the tax when, because of economic conditions, it could most easily be paid and to increase the tax when, in a depressed economic state, the tax becomes most burdensome. The recent British White Paper on *Employment Policy*[2] recommends the reverse policy.

[1] See, for example, "Experience Rating in Unemployment Compensation," C. A. Myers, *American Economic Review*, Vol. XXXV (June, 1945), pp. 337–354.

[2] Cmd. 6527 (reissued in the United States by The Macmillan Company New York, 1944).

The idea of experience rating seems to stem from its use in workmen's compensation insurance where the employer, by accident-prevention activity, can reduce the cost of industrial accidents and the associated compensation to the benefit of all concerned. There is grave doubt whether an individual employer can reduce the unemployment risk of his employees except that due to seasonal fluctuations which usually constitute the least serious risk. There is also evidence that the gains in other respects to the employer of reducing this type of instability in his operations are such that, once he has recoginzed the opportunity, the incentive of reduction in his unemployment-insurance tax is not necessary. There is, however, wide variation among industries in employment stability which the experience-rating scheme tends to recognize and to make proper adjustment for in the relative effective tax rates. If experience rating were discontinued, it might be necessary to make some adjustment in the tax rates by industries. This would be a difficult job at best and would bring about other unsatisfactory conditions.

In addition to the types of social-insurance provisions reviewed herein, the Social Security Act also provides for grants to the states for aid to the blind.[1] Several of the states had plans in existence as they had for dependent children.

SUMMARY

1. Poverty is not always due to lack of thrift, but much of it is due to loss from the insurable risks of

- *a.* Premature death of one having dependents:
  - (1) From occupational accident or disease.
  - (2) From other causes.
- *b.* Disability, temporary or permanent (invalidity):
  - (1) From occupational accident or disease.
  - (2) From other causes.
- *c.* Superannuation.
- *d.* Unemployment.

2. Adequate voluntary insurance against these risks is rarely carried by those most exposed to them.

[1] Title X.

3. Among the reasons for inadequate insurance is the high cost of private insurance due to unavoidable high operating costs.

4. Voluntary cooperative insurance has not met the problem in a satisfactory way.

5. The state has an interest in the prevention of poverty

   a. Because of the cost it imposes on the state.
   b. Because distress of any part of its citizens is of concern to it.
   c. In self-defense against degeneracy.

6. Industry has a responsibility and an interest

   a. To the extent that wages paid do not permit adequate provisions for the risks which cause poverty.
   b. To secure a body of competent, satisfied workers.

7. On these grounds justification is found for dividing the cost of such insurance among the workers covered by the insurance, employers, and the government.

8. It is essential to the success of a social-insurance scheme that its application be compulsory.

9. It is essential that costs of operation be kept at a minimum and that the need of defense against adverse selection be minimized, both of which conditions point toward a monopolistic carrier under strict governmental regulation and with governmental cooperation in collection of contributions. Stamp systems are frequently used for collecting premiums.

10. Social-insurance systems as a governmental policy were established in Germany in the decade 1881 to 1890 and have since been adopted, in whole or in part, by most of the European countries, and by Australia and New Zealand.

11. The United States has been slow to adopt the idea of social insurance.

12. Prior to 1935 the principle of workmen's compensation for industrial accidents had become generally accepted, but no real start had been made on other parts of a social-insurance system.

13. Agitation for a more complete system had, however, been going on, and some measures of a quasi-social-insurance nature had been adopted, such as mothers' aid laws and old-age-pension laws.

14. The Social Security Act of 1935, as amended in 1939, fosters social-insurance measures by taxation for their support, by abatement of taxes to the extent of contributions to state unemployment-insurance plans, and by direct grants-in-aid.

15. The Social Security Act sets up a plan of compulsory old-age and survivors'-insurance benefits (annuities).

16. One state has adopted a plan of compulsory sickness insurance.

17. Legislation is pending in Congress for broadening the Social Security Act both as to the employments and the risks covered, including in particular cash and service disability benefits.

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CHAPTER XXX

COMPULSORY AUTOMOBILE INSURANCE

The development and widespread use of the automobile have been one of the outstanding characteristics of the present century in the United States. Use of the automobile by all but the poorest has resulted in serious congestion on the streets and highways; its speed has raised problems of safety and of indemnity to the injured.

Problem of Automobile Accidents.—Accidents have inevitably resulted from these conditions, evidence of which may be found by an examination of the files of any metropolitan daily, especially of the Monday morning issues. Such an examination will also show that these accidents result in a large proportion of serious and fatal injuries. It is, therefore, not necessary to convert this chapter into a chamber of horrors by reciting the details of individual cases, or by the quotation of appalling statistics. Despite vigorous safety campaigns, the numbers are rising instead of falling, and there is little comfort in showing that the rate per automobile is falling when the rate per capita is rising, unless the saturation point in automobiles is being reached.

It is fashionable at this point to divert the discussion to a consideration of cause, to condemn the reckless speeder and the road hog, to suggest that motor-vehicle laws be more strictly enforced and that their violation be more frequently penalized by jail sentences and revocation of licenses. It has been suggested that special speedways be constructed and that special parts of the highways be reserved for high-speed traveling, and experiments of this kind are being made. On the other hand, one hears proposals that manufacturers be required so to construct cars that certain maximum speeds cannot be exceeded. Straightening and marking roads and the elimination of grade crossings are measures that are being advocated and tried. The loss from accidents is so serious that no reasonable effort should be spared to reduce it. But only the type of blind who will not see can

deny that, when everything practicable has been done, serious and fatal accidents will still occur in large numbers. The problem of properly providing for the victims and those dependent on them must be squarely faced and adequately met.

Injuries arising out of the operation of automobiles are at present dealt with under the common law of negligence.[1] Under that law each individual is charged with the duty of responding in damages to any one injured in consequence of his negligent action. In theory, any person injured by an automobile negligently driven by another may recover indemnity from him, though an expensive lawsuit may be a prerequisite. Practically, the financial resources of the operator also determine whether recovery can be had and, if so, to what extent.

Irresponsible Owners and Drivers.—It is of the utmost importance to the injured that the tort-feasor be financially able to respond in damages. Is this always the case? Again the reader may prove for himself that the answer must be in the negative by standing on almost any corner for an hour, watching the passing line of vehicles, and estimating from their appearance the probable financial worth of the operator. Occasionally he will be misled, but surely he will conclude rightly that not all are responsible and that there are certainly some, frequently those taking the longest chance in their manner of operation, from whom he would not expect to recover.

But do the irresponsible constitute a large proportion of the total? There are no statistics on this point, and resort must be had to estimate. There are two methods of approach, both of which the author has used to answer the question for the state of California, which is sufficiently typical for the country as a whole, at least to give the general dimensions of the problem. The first approach is through the extent to which credit is used in the purchase of cars. It is generally thought that 80 per cent of all cars sold, including secondhand cars, are purchased on an installment basis. Even very wealthy people may, and do, so purchase. But the charges on the deferred payments usually represent a very high rate of interest on the credit extended. People whose financial condition permits it avoid such charges. Hence, although less than 80 per cent may be considered as buying on an

[1] See pp213. -214.

installment basis from necessity, perhaps 75 per cent may fairly be estimated to be in such financial condition that, if they could respond to a substantial judgment for damages, it would be only at the price of such reduction in their living standards as would be socially almost as undesirable as to have the injured go unindemnified.

The second approach is through a comparison of the number of registered automobiles with the number of persons reporting incomes of $2,000 and over to the Treasury Department. Here, of course, allowance must be made for cars owned by corporations and by those individuals owning more than one car, factors on which no information is available. There is, therefore, a large element of personal judgment in both estimates. But taking precautions to make the estimate conservative, the result by both approaches is a conviction that more, rather than less, than 70 per cent of automobile owners are not qualified by property ownership to respond to a verdict of $1,000, a rather moderate indemnity for serious injuries when lawyer's fees and court costs are deducted.

In 1932 there was published the *Report by the Committee to Study Compensation for Automobile Accidents to the Columbia University Council for Research in the Social Sciences.* That Committee made case studies between Dec. 13, 1929, and Mar. 7, 1931, of a total of 8,849 cases of personal injuries occuring mainly during 1929 in six cities and four town, rural, and suburban communities in six states: Massachusetts, Connecticut, New York, Pennsylvania, Indiana, and California. "Each case was investigated by a personal interview with the injured person or with a member of his household who could give reliable data." In 1,448 of these cases the insurance status of the motorist was, for various reasons, unknown. In 860, the data on losses were insufficient or the injured received workmen's compensation; 85 cases involved only disfigurement and were not separately studied; 1,494 cases involved disabilities of one day or less. The remaining 4,962 cases were used as the basis of conclusions with respect to receipt, adequacy, and promptness of compensation. They included 3,926 cases of temporary disability, 499 cases of permanent disability, and 537 fatal cases.

Of the *temporary disability cases,* 541 were not yet settled. In

2,461 of the closed cases the motorist was insured, in the other 924 cases he was not. The proportions of the cases in which compensation had been received was: insured 86 per cent, noninsured 27 per cent. The proportion of these cases in which losses were covered by the net amount received was: insured 69 per cent, noninsured 11 per cent. In 63 cases (54 insured, 9 noninsured) the amount of compensation was unknown. In both groups, the larger the amount of loss, the smaller was the ratio of payment received to the loss, but the proportion fully paid by the noninsured motorist fell off more rapidly.

Of the *permanent disability* cases, 282 (192 insured, 90 noninsured) were closed. The proportion of these cases in which some payment had been made was: insured 96 per cent, noninsured 21 per cent. In cases of permanent disability it is difficult to appraise the total loss of the injured. The committee compared the amount received to loss (expense and loss of earnings) up to the time of investigation in the 250 closed cases (168 insured, 82 noninsured) in which the amount received was known. The amount received failed to cover this amount of the loss in 37 per cent of the insured cases and in 95 per cent of the noninsured.

Of the 537 *fatal* cases, 192 (154 insured and 38 noninsured) were still open, leaving 345 (190 insured and 155 noninsured) closed. Some compensation had been received in 88 per cent of the insured cases, but in only 17 per cent of the noninsured, despite the large proportion of the insured cases still open. In 93 per cent of the noninsured cases either nothing was paid or the net receipt was less than the medical expense and cost of funeral!

Is there not, then a public duty to provide some assurance to the public at large that, if a driver injures anyone, the injured, if not at fault, will be indemnified? A substantial property qualification as a prerequisite to license to own or operate an automobile would be so repugnant to American ideals that he would be bold indeed who would even suggest it. What else is there?

Compulsory Liability Insurance to Assure Responsibility.—As explained in Chap. XII, the liability-insurance policy written by American companies, though originally a strict contract of indemnity, came to contain a clause giving the claimant against the insured a direct claim against the company if a judgment was returned unsatisfied because of bankruptcy of the insured. It

now promises to pay the claimant direct. If a financially irresponsible operator is insured under such a policy, the legal rights of the victim are protected to the extent of the limits of the policy. It has accordingly been proposed in many states that the carrying of such a policy by the owner, or other evidence of financial responsibility, be made a prerequisite to the registration of any automobile. Bills to that end were first introduced about 1920 but, up to the present writing, Massachusetts, whose act came into effect Jan. 1, 1927, is the only state to adopt such a law applicable to all automobiles. Many states and cities require such insurance, or an equivalent surety bond, of all common carriers by motor vehicles, including interurban lines, taxicab companies, and jitney-bus operators, and the Interstate Commerce Commission makes similar requirements of interstate carriers.

The passage of such general *compulsory laws* has been generally vigorously opposed by the representatives of the insurance carriers. Inasmuch as such laws will apparently bring them a large increase of business, it is pertinent to seek the basis of such opposition.

Basis of Insurance Company Opposition.—When the state establishes any prerequisite to a right which it has previously freely granted its citizens, there is an implied obligation to see that the prerequisite is obtainable at the lowest possible expense and trouble. No matter how necessary the citizens may feel the prerequisite to be, they will strongly insist that this obligation be met and use their ballots to enforce that insistence. As to required insurance in private carriers, this means rate regulation and the setting of a fixed maximum rate. As has been pointed out in the discussions of rate making and of state supervision, regualtion of rates implies regulation of expenses. It may also mean reduction of agent's commissions. This would appear to be logical since, the insurance being compulsory, it should not be necessary to sell it. But the competition between the agents of the several companies is very keen, and it is necessary to solicit as before, and also to keep office records of expirations and other data in the agency to meet competition. Consequently, the agents complain that, with any notable reduction in commissions, the result of even the largely increased business will be a very

slight increase in their net revenue and may be a reduction. For obvious reasons the agents hold a powerful influence over home-office officials who tend to defend their interests.

There is also the fear that the state-approved rates may not prove adequate[1] and that it will not be possible to correct the inadequacy before serious injury is done to the companies. The basis of this fear lies in the fact that the state authorities, whose rate-making method must pass public scrutiny, insist on a statistical basis. It is a notable fact that juries are more liberal, both in determining the facts that fix the liability and in awarding damages, if a supposedly rich corporation must pay than in the case of a private citizen. It is, therefore, anticipated that judgments will be more frequent and larger, that it will be difficult and expensive to settle out of court, and that this will be a progressive tendency for some time after such a law becomes effective. If these anticipations are realized, the costs for the period for which rates are made will be a little more than those of the period used as a basis of rates.[2] Although the state authorities will have no desire to produce inadequate rates, they will find great difficulty, until such tendencies are clearly evident, in justifying the inclu-

[1] This fear appears to be well founded. Ralph H. Blanchard has made careful and comprehensive studies of the operation of the Massachusetts act. He published one study in October, 1936, "Compulsory Motor Vehicle Liability Insurance in Massachusetts," *Law and Contemporary Problems*, Vol. III, p. 537. Later he released in mimeograph form a new set of data covering the period from 1927 to 1938, inclusive. In one table are shown for each policy year the incurred losses and the provision for losses in the rates. Only in the policy years 1932, 1936, and 1938 was the provision adequate. Over the 12-year period, the aggregate losses were $182,931,391 and the provision for them in the rates was $169,864,769. The deficiency $13,066,622 was 8 per cent. In only one year (1936) was the provision in the rates adequate for stock-company expenses. Most of the time the average stock-company expense was about 103 per cent of that provided for in the rates.

Other sources show that political pressure was put on the Commissioner to keep rates low, and efforts were made by various local authorities to obtain rearrangement of rate areas to reduce the rates applicable to cars garaged in their respective towns and cities.

Despite the inadequacy of the rates, no important carrier ceased writing the business. The losses were not disastrous to any reputable carrier.

[2] Blanchard's data show the following comparisons as to average loss cost and claim frequency:

sion of factors for them, as there would be public criticism that the rates were based on the fears of the underwriters rather than on statistical data.

In the case of workmen's compensation, it is essential that each industry required for the needs of the community be able to secure the required insurance at a reasonable cost. The same argument may not apply with equal logical force in the case of bodily-injury liability insurance for automobile operators, since not always is the privilege of operating an automobile, by a partic-

PERCENTAGE CHANGES IN AVERAGE LOSS COST PER CAR
1927–1928 (inclusive)

	Per Cent
Massachusetts (stock and mutual)	+12
Stock companies in 10 states with large automobile registration*	−10
Stock companies (country-wide, except Massachusetts)	−11

* California, Connecticut, Illinois, Missouri, New Jersey, New York, Ohio, Pennsylvania, Virginia, and Wisconsin.

1930–1938 (inclusive)

Massachusetts (stock and mutual)	− 5
Five states† (stock and mutual)	−27

† New Hampshire, New York, North Carolina, Texas, and Virginia.

PERCENTAGE CHANGES IN AVERAGE CLAIM COST AND FREQUENCY
1927–1938 (inclusive)

	Country-wide except Massachusetts*	Ten states*	Massachusetts†
Average cost per claim	+14	+18	−12
Claim frequency	−21	−24	+33

* Stock company figures.
† Stock and mutual figures.

Apparently the compulsory insurance law has led to the presentation of a great proportion of small claims. If the injured does not know or, at least, believe that a motorist is insured, he may not consider it worth while to present a claim. Hence, probably the lower claim frequency outside Massachusetts. Increased frequency of small claims tends to reduce the average cost per claim. The figures in the first two tables seem to indicate more large as well as small claims during the first 2 years of the act.

ular citizen, a necessity to his earning a livelihood,[1] or to the well-being of the community. Indeed, it is to the interest of the community that certain drivers be denied the use of the roads, and it is one argument for compulsory insurance that reckless drivers, unable to get insurance, will be driven from the road. But citizens, while acquiescing in the general theory, think in terms of their personal affairs and are unwilling to take the chance of being themselves deprived of the privilege arbitrarily by the action of a private corporation, or a group of private corporations, "just because they have had a little hard luck." So a new principle has been introduced into insurance practice in the Massachusetts law and in other proposed laws, the requirement to issue a policy unless satisfactory reasons why it should not be issued can be shown to a public commission. As every underwriter knows, moral hazards are real and have been very costly. But the irony of the situation is that often the worst moral hazards are those it is most difficult to present to a public commission so as to win their approval of the rejection. Furthermore there is always the danger of effective political pressure from the rejected applicant. The author is not familiar with the details of cases brought before the Massachusetts board or the reasons for its decisions, but the companies have been sustained in less than one-third of the cases brought before it.[2] On Nov. 15, 1939, the Massachusetts Auto-

[1] It is becoming increasingly so in the case of carpenters, masons, and some similar trades in which the mechanic must carry his tools with him to his job, and even for others with the present tendency for increased suburban residence.

[2] Blanchard also gives data on this point. Figures for the years prior to 1930 are incomplete. For the 10-year period, 1930–1939, there were 35,159 complaints to the board on account of cancellations.

These were disposed of as follows:

Cancellations	Number	Per cent
Sustained	12,467	36
Annulled*	17,677	50
Dismissed	1,762	5
Continued	3,253	9
Total	35,159	100

* 12,731 (36 per cent) "reinstated by the carrier." Did the carrier foresee that the complaint would be sustained anyway?

During the same period there were 15,577 complaints on account of

mobile Rating and Accident Prevention Bureau adopted an assigned risk pool,[1] beginning its operation with policy year 1940.

Lastly, there is always the threat of a state fund, either as a competitor or as a monopolistic carrier to the exclusion of the private carriers. Many a conservative businessman who would most vigorously oppose the entrance of the state into the business of transporting or manufacturing, or even direct construction and repair of its own roads by day labor rather than through a private contractor, has no such feeling toward its taking over the insurance function. This can be explained partly by the fact that other activities seems more like an invasion of his own field and means of livelihood, partly by the records of graft and inefficiency in previous government experiments, and partly by ill will toward the insurance carriers, who, in his opinion, overcharge and underpay. The average businessman has not studied the insurance business and fails to understand its operations or the terms of insurance contracts.

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refusal of insurance. These were disposed of as follows:

	Number	Per cent
Refusal sustained	2,739	18
Not sustained	2,524	16
Dismissed*	10,302	66
Continued	12	0
Total	15,577	100

* 6068 (39 per cent) listed as "carrier agrees to issue."

Figures for appeals to the courts were not available for years prior to 1937. For the 3-year period, 1937–1939, there were 498 appeals, disposed of as follows:

	Number	Per cent
Board action affirmed	238	48
Reversed	192	38
Otherwise disposed of	68	14
Total	498	100

[1] See pp. 307*n*.

Although the above are the real grounds of opposition of the insurance interests, obviously such a presentation of the case would gain little sympathy from the public at large, and open opposition has been based on other grounds. Some of these are valid objections from the standpoint of the public and should be examined.

Objections Purportedly from the Standpoint of the Public.—The objection to compulsory insurance claimed to be most serious rests on the alleged inadequacy of the proposal. It is exceedingly difficult to enforce as to the occasionally visiting car. In a state that is interested in promoting tourist travel it will be deemed undesirable to impose conditions which will divert that travel. If those conditions are not imposed,

1. There is discrimination against the state's own citizens.
2. There is still an uncovered field for accidents, *viz.*, those arising out of the operation of visiting cars.

Lack of uniformity among the states in their requirements may become a burden on the motoring public. These are important details but do not reach to the principle involved. Further along this line, it is pointed out that such laws require only that the policy cover operation on public highways, and that accidents on private ways such as gasoline filling stations need not be covered. Probably, however, the officials approving the form would not insist that it be limited to the required territory, and competition and other forces would lead to the more general coverage.

A liability policy, even the most liberal form, covers only the insured owner and those operating the car with his permission. Many of the most serious injuries are caused by the operation of stolen cars, which would not be covered. Unless the hit-and-run driver is apprehended or his car identified, there could be no recovery by the victim, because it could not be ascertained what insurance carrier was liable.

The liability policy is primarily an insured's defense policy, and it is necessary to establish negilgence in order to enforce a claim. Not only is this so but, unless the law of negligence is changed, the burden will still be on the victim to establish himself as free of negligence. Accidents rarely happen when cars are moving slowly, and even the trained eye of the pro-

fessional baseball player misgauges the flight of a pitched ball. Can casual witnesses be expected to do better? Unless their statements are obtainable instantly, there is great likelihood of varying interpretations due to reflection and emotion. And in the case of two-car collisions, the matter becomes more complicated. It is said that damage suits are the greatest incentives to perjury in American life, and the remark probably applies with equal force to both sides of the case.

Along with the question whether the scheme can reach all the needs, goes the fact that greater assurance of recovery will promote more suits, and that the cases, all being handled by specialists, will be more skillfully defended. Greater congestion of the courts may well be looked for.

It is also alleged that there will be more improper cases, "guest" cases and others, and that juries will be more likely to allow damages.

All these objections appear to be serious, and to merit due consideration but do not answer the compelling argument, supported by the data quoted on pages 580–591, that there is need of some means of assuring that the innocent victim of an automobile accident should be properly cared for and indemnified.

Prevention of Accidents More Important than Indemnity.— This book has fallen short of its purpose if it has not made plain long since that insurance merely eliminates risk, but leaves the actual loss as a community burden, though the individuals and organizations engaged in the insurance business strongly endeavor to minimize the actual loss. Prevention of loss is always preferable to indemnification of those suffering from preventable loss. Especially is this so when the loss involves human suffering for which no monetary indemnity can compensate. It is, therefore, argued that, when the question of assuring financial responsibility is given such prominence as in the present case, the problem is being attacked from the wrong side. What should be done is to prevent all possible accidents and then consider the securing of indemnity, if that is necessary. This approach seems equally faulty. It has already been pointed out that not all accidents can be prevented, and that it is unfair to the victims to postpone all consideration of indemnity until the maximum of prevention has been accompolished, especially when

it is realized that a little more can always be done, so that the maximum is never attained. Both programs can, and should, go forward together; they are complementary, not antagonistic. It is, however, most important that the method of providing indemnity shall not impede or impair the preventive effort. From this point of view certain other arguments should be considered.

It is alleged that the fact of insurance and the freedom from direct financial responsibility will encourage recklessness, which will not be curbed by the fear of refusal to renew the insurance, because business and political pressure may be brought to bear to force renewal. The argument appears to have little merit.

Alternative Suggestions.—To meet the various objections just raised, several alternative plans have been proposed, none of which are wholly without merit but each of which is subject to more or less criticism from one or several points of view.

All but two of the alternatives have, after a brief discussion, ceased to receive the attention of the public. Two appear to warrant attention here: financial responsibility laws and a compensation plan. The former have been advocated by the American Automobile Association which in 1928 prepared a draft of such a law and revised it in 1930.[1] They have also received the support of the insurance interests. The latter has been advocated by many different interests, the most prominent and persuasive being the Committee to Study Compensation for Automobile Accidents composed of lawyers and judges and assisted by experts in insurance and other fields, appointed by the Columbia University Council for Reaserch in the Social Sciences. No state has adopted the compensation plan.

Financial Responsibility Laws.—Financial responsibility laws have been adopted in all but 13 states and in all of the Canadian provinces, except Quebec. The laws seem to follow Theodore Roosevelt's admonition, "Speak softly but carry a big stick." Generally they fall into one of three groups:

1. Those which require suspension of an operator's license or registration, or both, unless proof of financial responsibility for the future is filed, in case of failure to pay a final judgment or

[1] With subsequent amendments.

conviction of certain traffic violations, but without requiring the satisfaction of any outstanding judgment.

This form of law is the most lenient. It is in effect in only one state—Connecticut.

2. Those which require suspension of an operator's license or registration, or both, in case of failure to pay final judgment, until the judgment is satisfied and proof for the future is filed; also commonly in case of conviction for violation of certain traffic regulations.

This is the most common type of law.

3. Those which require suspension of operator's license or registration, or both, within a specified time, *e.g.*, 10 days, when the operator is involved in any way in an accident resulting in bodily injury or damage to property in excess of a certain amount unless the operator or owner or both (*a*) has previously furnished or immediately furnishes *security* in an amount deemed necessary, up to $5,000 for injury to a single person, or $10,000 for a single accident, and $1,000 for property damage, to cover such damages arising out of the accident as the person may be responsible for, and (*b*) furnishes proof up to the same limits for the future. Conviction for violation of certain traffic regulations invokes the same requirement.

This type of law, the most recent and most rigid, is in effect in six states.

As to financial-responsibility laws, in general, it has been said they are "based on the assumption that 'Every dog is entitled to one bite' and if either we are the victims or the dog is mad, that is one too many."[1]

Of course, it is easier to get insurance before it is required, and such laws do probably promote fuller insurance of the motoring public but not so full as a genuine compulsory-insurance law. The carriers do not like to issue the required insurance after it is required but, to head off the demand for a state insurance fund to furnish the insurance, they do so in most cases. In most states assigned-risk pools have been organized.

Compensation Plan.—As its name implies, the *compensation* proposal is to apply to automobile accidents the same principle as

[1] *Transactions of the Commonwealth Club of California*, Vol. XXI, p. 200 (1926).

is applied to industrial accidents by workmen's compensation laws. That is, the plan proposes to impose on the owner of a motor vehicle a limited liability without regard to fault. The owner of any vehicle that causes disability or death must pay compensation if the vehicle at the time of the accident was driven by him or by another with his consent.

The benefits to be provided are similar to those under the compensation law. For professional and businessmen profits are to be taken in lieu of wages and for housewives wages are to be assumed to be the same as those paid for similar work at the time and place of their occupation. For permanently unemployed persons, unemployed minors, and studends over nineteen, the minimum compensation is to be taken. Maximum and minimum limits of benefits are to be set at about the same points as in the workmen's compensation laws.

The compensation is to be made the exclusive remedy. Insurance is to be compulsory. Special provisions are suggested to settle the liability in the case of collision between cars.

Bills to provide for such a system have been introduced in the legislatures of several states but none have yet been passed. It is stated that liability is imposed without fault by the laws of Finland, Norway, and Denmark.[1]

The Columbia Committee came to advocate such a solution of the problem after a survey in several parts of the country of the operation of the negligence liability laws. These studies showed heavy congestion in the courts due to the liability cases with consequent cost to the public. More important was the evidence produced that, where insurance is carried under the present system, the tendency is for the cases of temporary and minor permanent injuries to be more than compensated and for the recoveries in the serious cases to be woefully inadequate and long delayed. The settlements were larger when the motorist carried insurance than when he did not.

Briefly, the criticism of the liability system is the same as that of the employers' liability system.[2]

[1] *Report of Committee to Study Compensation for Automobile Accidents*, p. 112.

[2] *Ibid.*, Chaps. I–V.

The two most important objections raised to the proposal seem to be

1. That the relation of employer and employee which makes workmen's compensation laws workable and which gives the employers the opportunity to improve working conditions and make them safer is absent in this case.

2. That the compensation is very inadequate in the case of those in the higher income brackets, professional and business people. Despite the grossest negligence of the motorist who injured them, they would have no other redress. To give it would break down the whole system.

To the author, perhaps because he is in the latter class and is also an occasional motorist, no really satisfactory solution of the problem has yet been presented. One of his colleagues has suggested that, if the compensation plan is adopted, all those whose earning power is such that the benefits under the plan would not be adequate to their standard of living should certainly protect themselves and their dependents by adequate life and accident disability insurance. In the light of the evidence as to the proportion of irresponsible motorists, even in states having financial-responsibility laws, that would appear to be good advice regardless of whether or not a compensation plan replaces the negligence law.

The author is not wedded to any of the proposals reviewed, seeing merits and defects in all. He is, however, firmly convinced that action must and will be taken in the near future, and that it will be futile if not fatal to any group or interest, insurance carriers, automobile dealers, manufacturers, or others to attempt selfishly to prevent or unduly delay action in the purported hope of a perfect solution. In the absence of a compensation plan, it would appear that improvement in the present method of assessing damages by a more accurate and speedy determination of liability and of the amount of damages is imperative. Reallocation of costs resulting from compulsory insurance and improvement of administration of the liability should not be confused with the idea of increasing the costs. Increased cost would result only if the damages awarded exceeded the victim's loss.

SUMMARY

1. A large number of persons are injured by automobiles, the owners of which are unable to pay indemnity.
2. Attention to prevention of reckless driving may reduce the dimensions of the problem created by such injuries but will not eliminate it.
3. Compulsory liability insurance has been suggested as a remedy and is being tried in Massachusetts.
   - *a.* There is strong opposition to this system from those in the insurance business, partly on selfish grounds.
   - *b.* There are serious defects in the system as a complete remedy.
4. Prevention of accidents is more important than indemnifying the victim, and any proposal for the latter must not impede but should encourage the former.
5. A number of alternative plans have been presented, including one of substituting the compensation principle for the action in tort.
6. All proposals have both merits and defects.
7. It is probable that, in the near future, the remaining states will enact some law to meet the problem, as it is pressing too strongly on public attention to be put aside.
8. The automobile itself, by facilitating communication and by bringing the same individual in a short time under the laws of several states, will probably be a strong force toward ultimate uniformity.

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CHAPTER XXXI

INSURANCE IN SOCIAL EVOLUTION

Having defined the field of insurance, established the fundamental principle on which it operates, and reviewed briefly present applications of that principle, it is the purpose of this closing chapter to survey the record and fix the place of the institution in the evolving social order. In such a survey should be found the orientation and guiding principles for the conduct of those in responsible charge of our present business in its broader relations.

Ever-widening Field for the Application of the Insurance Principle.—The first fact that strikes one, on undertaking such a survey, is the slow and gradual growth of insurance over the centuries, and its rapid expansion in recent years to meet a multiplicty of conditions undreamed of a century ago. In its first crude application through the respondentia loan among the ancient Sumerians, the principle was made to serve for the elimination of only one hazard of that day, that of loss by brigandage of goods in transportation. As passed on through the Phoenicians, Rhodians, Greeks, Romans, and Medieval Mediterranean traders, it was transformed to cover the peril of piracy and extended to include all the perils of marine transportation. At some time in this period, direct insurance took the place of the indirect respondentia loan. No further extension took place until the seventeenth century, unless we accept the uncertain evidence that life insurance was practiced to some extent among the ancient Romans, though mutual-aid organizations, among both the ancients and the medieval guilds, eliminated some of the risks of personal disability. After the great London fire of 1666, came the application of insurance to the next outstanding peril, fire. Early in the next century, after a prelude of speculative insurance on the lives of sea captains and other travelers, life insurance began. And for more than 100 years, there was little further advance.

In the latter half of the nineteenth century, modern extension began. In the United States, the first of what are now known as casualty-insurance companies were established to write personal-accident insurance. At first timidly, but later boldly, these companies extended coverage to other risks, as reasonable bases for the business were found. The fire-insurance carriers added the tornado and other property lines. Abroad, the crude and limited mutual-aid associations were brought into the great social-insurance systems.

Field Not Yet Fully Covered.—There yet remain many fields into which insurance has ventured little, if at all. The field of aviation insurance, for example, is yet in the developmental stage. A still more important, though less spectacular, field is that of agricultural insurance. So far ventures in that field have not been successful.[1] But it should not remain indefinitely without coverage. The farmer is exposed to many risks which he must still carry alone: drought, insect, and other pests, excessive moisture, and many other causes of crop failure, as well as adverse market fluctuations. The difficulty has been to confine the risk transferred to, and assumed by, the carrier to real risks, without making it possible to unload on the carrier the consequences of the insured's neglect. A way must, and will be, found to accomplish this. But when insurance has covered all the fields now known, the limit of extension will not be reached. Creation of risk is one of the prices of progress. With progress, new risks will arise and insurance will be extended to cover them.

Insurance Promotes Prevention.—A second fact that strikes one reflecting on the growth of insurance is that progress in eliminating loss follows the extension of insurance to any field. There are several reasons for this. The process of selection by the carriers requires that they learn to distinguish differences in degree of risk. Inability to get insurance, once insurance becomes available to the community, sharply calls the attention of the owner of a bad risk to its defects. He seeks to remedy

[1] Some success is claimed for the Russian state insurance of coöperatives in this field. See RYBNIKOFF, S. A., "Insurance in the U.S.S.R." *Harvard Business Review*, Vol. XIV, pp. 425*ff*.

The United States is at present trying out crop insurance in a limited way. See pp. 300–301.

them so that he may qualify. Or, if his rate is higher than his neighbor's or competitor's, he seeks to improve his risk so that he may enjoy as low a rate. With the concentration of losses in one sum their importance may be brought home to the community, and the saving to be made by their prevention made evident. Once the risk has been transferred to the carrier, any reduction represents clear financial gain to it, which furnishes an incentive to stimulate safety education, even though the rate may later be reduced. Service in the prevention of loss is also a recognized competitive appeal.

This tendency of insurance to promote the elimination of the causes of risk and loss led the late Josiah Royce, Professor of Philosophy at Harvard University, to suggest that perhaps, through some international application of the insurance principle, the risk of war might be banished.[1] Professor Royce had no detailed plan in mind, but the suggestion of the idea near the outbreak of First World War was striking evidence of recognition of this influence of insurance.

Insurance Must Be Sold or Its Purchase Compelled.—Since the first cave man maintained his precarious existence, human life has been full of risk. A life entirely devoid of risk is unthinkable. The acceptance of risks is a part of our nature, much though we shudder when first confronted with a new one. Adjusted to a risk, we learn to close our eyes to it, ignore it, and even when, later, the opportunity is available to transfer and be rid of it, we do not run to seize it. We are indifferent. The transfer must be forced upon us, or we must be persuaded to it. For the transfer involves cost, present sacrifice and, if we have steeled ourselves to forget and ignore the risk, we have to have its existence again forced upon our attention that we may realize that insurance represents a *quid pro quo.*

These observations are apparently contradicted by instances where the demand for insurance arises before it is offered, such a demand as is implied in the assertion quoted in an earlier chapter that the development of aerial transportation was retarded by inability to procure adequate insurance. These, however, are only apparent contradictions. There were aviation enthusiasts before any insurance against its perils was

[1] ROYCE, JOSIAH, "War and Insurance."

available, and even when participation in aeronautics suspended the coverage of life-insurance policies during such participation. Commercial development of aeronautics requires capital and credit. The traditional conservatism of capital and credit and the demand for security were stressed in the first part of this book. In commercial ventures the pressure of lenders for security emphasizes the risk and forces insurance.

Where the pressure of lenders does not act as an impelling force, some other means of persuasion or compulsion is necessary to procure the carrying of insurance. It has already been pointed out that life insurance must be sold, and that almost all men carry far less life insurance than will serve to give adequate protection to their dependents. Where it is commercially feasible, salesmanship is used. By commercially feasible is meant a condition where enough insurance can be sold to obtain a reasonable spread of risks, at rates that will pay selling cost. Thus, rates for industrial life insurance are much higher per dollar of insurance than for ordinary-life insurance, because of high expenses. Yet the soliciting agents do not receive large incomes. Indeed, there has been grave criticism of their low average earnings. Much higher rates could not be collected, however, and an adequate volume of business written, even though better salesmen could be secured for higher rewards. Where it is not commercially feasible to use salesmanship, commercial insurance does not enter, and even the most efficient salesmanship cannot sell to the entire population exposed to risk.

To reach the mass of the population, compulsion by the state is necessary. Thus we are led back to the subject matter of the two preceding chapters: the use of compulsory insurance in state policy. The objections to compulsory automobile-liability insurance were discussed at some length in the last chapter, but little has been said of the objections raised to social insurance.

Objection to Social Insurance as Paternalism, Socialism.— The most common objection in the United States to proposals for the introduction of social-insurance systems is that they are paternalistic, contrary to the spirit of our people, and that paternalism stifles individual initiative, the cause of our growth and progress. Let it be admitted that such schemes are paternalistic. Let it also be admitted that difficulty develops, if it

does not generate, initiative, and that ease and luxury deaden it. Is not a limitation on this last proposition necessary? Is it not possible that the obstacles to be overcome may be so great as to stifle hope and kill initiative? Certainly, hope and ambition are the mainspring of initiative. Even under the most complete system of social insurance, are conditions made so easy as to remove all stimulus to initiative? It must be admitted that the removal of such risks as are covered by social insurance makes life more bearable for those who cannot otherwise improve their status. If this were not so, there would be nothing accomplished by its introduction. Is it reasonable to believe that this much improvement in conditions would satisfy a soul like that of Thomas Edison, or Henry Ford, or those others whose efforts to better themselves have made life better for all and helped to build our greatness?

Is it more paternalistic to protect the working classes of our citizens by compulsory social insurance than to promote certain of our industries by protective tariffs, to stimulate railroad building by grants of land, or to advance the progress of aviation by granting remunerative contracts for carrying mail? It may be answered that social-insurance schemes, by compelling the individual to act for his own good, aim to protect him aganist himself, against his own negligence, and that this is class legislation. It may be granted. Our whole system of supervision of insurance, not to speak of pure-food laws and many other regulations, is designed to protect us against our own negligence. And certainly such measures are no more class legislation than the tariffs, bounties, and subsidies previously noted, though the fact that the major benefits may inure to special classes is to a greater extent concealed in the latter cases. If the conclusion is that our whole government has been too paternalistic and is becoming more so, the objection is transferred from a specific scheme to a general policy, debate of which passes beyond the scope of this book.

It is also objected that such schemes are socialistic. Probably no word is more misused in the United States, or used with a more vague meaning, than "socialism" and its derivatives. Yet it must be admitted that support of social insurance is a part of the program of the state socialist parties abroad, and to that

extent the charge may stand. Does so branding the proposal damn it? With those to whom the word is anathema, yes. But if its principles or practices do not lead to evil results, the thinking man should not so condemn it. Many things now generally admitted as highly desirable, and not in conflict with our realization of individual well-being, have been so condemned. Among examples that might be cited are municipally owned waterworks and other utilities.

Objections to the State as the Insurance Carrier.—Private insurance interests are generally opposed to state-managed insurance. If private enterprises are already in the field and have built up a substantial organization that can well serve the desired ends, it might be desirable to utilize these organizations, as England has done in administering her health-insurance system through the Friendly Societies. If private enterprise has not entered the field, the complainants have little standing in pleading vested rights before the bar of public opinion, but they should be permitted to show that they can serve the need better than the government. Even in the first case, it would appear that it should be shown that public interests will not suffer through the use of the existing agencies. That is, that they will not suffer in the sense not only that present conditions will not be made worse, but also that improvement will not be prevented. The existence of private interests in the collection of taxes did not preclude the abandonment of the practice of farming out the revenues, even though in an earlier time public interest may have been better served by that method. The existence of private educational institutions has not been allowed to prevent the establishment of public school systems.

The arguments based on the inefficiency of public services, and the tendency to bureaucracy and political manipulation under the spoils system, should have due consideration in determining whether state funds, or other types of carriers, are to be preferred as the means of applying the insurance principle to particular conditions. But in this connection such inefficiencies as inhere in these other types must also be given due weight.

These last observations lead to the further question whether it is reasonable to suppose that any one type of arrangement

may be considered best for all conditions. Unfortunately, sufficient experience is not available to give a determinative answer, but there are some facts. On the one hand, during the World Wars, risks arose from marine hazards and the hazards of death and disability to the members of the armed forces, which were too great for the existing insurance facilities to handle or for private enterprise to be willing to provide for. It was necessary to arrange for government bureaus to care for them. There are then limits beyond which private enterprise is not adapted to serve. On the other side, we have the state experiments in voluntary life insurance in Wisconsin, and in voluntary hail insurance in other states which have had, at best, dubious results, though the semicompuslory hail fund in North Dakota seems to have been successful. These cases appear to indicate that there are limits to the satisfactory operation of government bureaus. In general, it appears reasonable to say that, where fine distinction in hazard must be recognized or when insurance must be sold, government bureaus could hardly be expected to function well.

From the standpoint of the public, it would appear that the same rule should govern the furnishing of insurance service as is applied to other public needs. Those things which can best be done by private enterprise should be left to private enterprise, and those which can best be done by the state should be done by the state. There appears to be no valid objection to the state serving as an insurance carrier, other than that private enterprise can give better service, not merely to selected individuals but in the interest of the entire public. Where these limits lie can be known only from experience. It seems reasonable to suppose that those European governments were right which found that certain parts of their social-insurance programs required the services of public or quasi-public institutions. It does not seem to follow that the entrance of the government as the carrier in these fields will lead to its activities being further extended. Such was not the case in Germany (where social insurance as a state policy was most developed) prior to the accession to power of the National Socialist party.

Insurable Risks Arise Only in Individualistic Societies.—The most fearful see in compulsory-insurance proposals the bogey of

communism. It is worth while to examine the matter from this angle. A very little reflection indicates a fundamental conflict between insurance and communism, perhaps because, in a sense, communism is insurance. A communistic society may suffer serious losses, but the individual in a fully communistic society[1] is not subject to any risk to which the whole society is not also subject. If he has nothing of his own he has no risk, for he has nothing to lose. As to many things the society has no risk, or at least no insurable risk for, all property being held in common, the risk is eliminated by combination, and certainty of loss takes its place. If hazards are so low that, over the whole community, there is no regularity in the occurrence of losses, then the whole community is subject to risk, but no internal insurance would avail. Several communistic societies might insure each other, but a more logical action would be a wider communism. The mechanics by which the communistic society may provide for the use of its common properties and the replacement of losses constitute a problem that need not be considered here. The essential point to be made here is that individual ownership of the value that may be lost is an element of the risk with which insurance deals.

Insurance a Defense against Revolutionary Communism.—Communism has been a characteristic of abstract ideal communities described by philosophers in seeking the perfect state, but with little expectation of their realization by human beings within measurable time. Experiments with communistic settlements have been tried by philanthropists as examples, which it was hoped might prove so alluring as to lead the world to a better order. But neither the philosopher nor the philanthropist has been militant, though they may have inspired the militant.

The militant communist is he who has nothing to lose, or the idealistic fanatic who becomes imbued with the miseries of the lowest economic class. For them there is everything to gain and nothing to lose by the revolutionary drive, save perhaps life itself, which has been so hard. Possession of property and

[1] Since Russia is not a fully communistic society, there is state insurance of property, partly compulsory and partly voluntary (supplementary), and of the risks of the cooperatives and their members. See RYBNIKOFF. *op. cit.*

recognized rights makes us all conservative. If, as has been alleged with much truth, losses from risks to which the borderline economic classes are exposed constantly press them down into the pauper class, the proletariat of communistic theory, then does not the removal of those risks tend to cut off the supply of recruits to the cause of militant revolutionary communism? This argument has been advanced primarily as an exposition of the service of insurance by private carriers, and it seems to this author, with merit. The argument applies more strongly to social insurance, insofar as a complete system removes the hazard from a larger number.

Social Obligation of Private Insurance.—If the foregoing reasoning is sound, there appear to arise from it certain guiding principles to be followed by those charged with responsiblity for the conduct of the insurance business in the future.

First, it would appear that they should look upon their business, not as a private enterprise that should be so managed as to produce a maximum of profit for the proprietors, but rather as a trust committed to them for the service of the public, to be performed on the best possible terms and at the lowest cost consistent with proper service and fair remuneration to capital, labor, and management. What that fair remuneration may be, must be determined by the rewards paid in other activities. It may be remarked in passing that this principle of fair remuneration has been adopted by the courts in cases involving rates for public utilities, though they have found much difficulty in applying it.

Second, a principle implied in the first, that they should seek to extend their facilities to meet the needs of the public as rapidly as those needs develop and are recognized, and as the proper basis for rates and underwriting may be found. This seems to be the policy followed at present by the business as a whole.

Third, perhaps also implied in the first, where they are not prepared fully to meet public needs for risk bearing and cannot prepare satisfactorily so to do, they should not oppose the setting up of other suitable agencies lest the example lead to further extensions of these agencies to the detriment of the interests in their charge. This is a difficult position to take since proprietary

interests usually consider it disloyal. Yet, in the long run, failure to do so may mean more serious difficulties.

Fourth, again a corollary of the first but harder to apply, if private insurance is entered on a field which apparently can be better served by public funds, it should arrange suitably to abandon that field to public carriers and concentrate its attention on those whom it can best serve. This case has not arisen and may never arise. The consequences of failure to recognize it, and so to act when it arises, will be public disfavor in a degree proportionate to the seriousness of the case.

There appears no ground for fearing that within any reasonable time in the future well-conducted private insurance will be driven from the field.

All engaged in the business and honestly performing their part may feel keen satisfaction in being engaged in public service. second to none in importance and responsibility and in its contribution to the general welfare.

SUMMARY

1. The field of application of insurance has been ever widening, especially in recent years.
2. The field is not yet fully covered.
3. Insurance promotes prevention.
4. External pressure or persuasion is necessary to bring the individual to take insurance.
5. Where it is essential that insurance be carried and pressure of lenders or salesmanship cannot bring it about, compulsion is indicated.
6. Social insurance has been objected to as paternalistic, socialistic, and un-American, but examination shows that it is no more paternalistic or socialistic than many other measures that have been adopted, and that it may be accurate to say that it is in accord with the evolving American spirit.
7. Serious objections are raised to the state as an insurance carrier. Some of these are purely selfish and some are valid. Analysis indicates that there are fields for both state and private carriers.

8. Insurable risks are characteristic of individualistic, but not of communistic, societies.

9. By fostering the economic independence of the individual, insurance, including social insurance, is a defense against revolutionary communism.

10. Private insurance has social obligations, and its future well-being and growth depend upon a clear recognition of those obligations, and conduct to correspond.

11. There appears to be no likelihood that, within any reasonable time, well-conducted private insurance will be destroyed.

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APPENDICES

APPENDIX I

STANDARD FIRE INSURANCE CONTRACT OF THE STATE OF NEW YORK

No.

RENEWAL OF

[Space for insertion of name of company or companies issuing the policy and other matter permitted to be stated at the head of the policy:]

Amount		Rate	Premium		Total Premium
$______	Fire & Lightning	______	Fire & Lightning	$______	
	*Extended Coverage Endorsement	______	*Extended Coverage Endorsement	$______	$______

*No insurance attaches in connection with the Extended Coverage perils unless the "rate" and "premium" are inserted in the spaces provided above and the Extended Coverage Endorsement is "attached" to this policy.

IN CONSIDERATION OF THE PROVISIONS AND STIPULATIONS HEREIN OR ADDED HERETO

and of________________________________Dollars Premium

this Company, for the term of______________________________

from the____________day of____________, 19____ at noon, Standard Time, at

to the____________day of____________, 19____ location of property involved,

to an amount not exceeding______________________________Dollars,

does insure______________________________

and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all **DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED,** to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

In Witness whereof, this Company has executed and attested these presents; but this policy shall not be valid unless countersigned by the duly authorized Agent of this Company at

President.

Secretary.

Countersigned

*this*____________*day of*____________, *19*____ ____________________*Agent.*

Concealment, fraud. This entire policy shall be void if, whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property. This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included. This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other Insurance. Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. **Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring**

(a) while the hazard is increased by any means within the control or knowledge of the insured; or

(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or

(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Other perils or subjects. Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability. This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs. The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; **and within sixty days after the loss, unless such time is extended in writing by this Company, the insured shall render to this Company a proof of loss,** signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal. In case the insured and this Company shall fail to agree as to the actual cash value or

Added provisions. The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions. No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy. This policy shall be cancelled at any time at the request of the insured, in which case this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be cancelled at any time by this Company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations. If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a ten days' written notice of cancellation.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions

the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.

Company's options. It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment. There can be no abandonment to this Company of any property.

When loss payable. The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.

Suit. No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within twelve months next after inception of the loss.

Subrogation. This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

APPENDIX II

DWELLING AND CONTENTS FORM*

Attached to and forming part of Policy No.................................of..

....

NAME OF INSURANCE COMPANY

issued at its...Agency.

CITY OR TOWN STATE

This policy covers the following described property, ...Agent

AGENTS SIGN HERE

all situated..

HERE GIVE STREET NUMBER, OR LOT OR BLOCK NUMBER OR TOWNSHIP, SECTION AND RANGE

City / Town of...State of..

*Item 1. $............................ON the..roof...family dwelling,

ROOF COVERING CONSTRUCTION NUMBER

....

including building equipment and fixtures and outdoor equipment pertaining to the service of the premises (if the property of the owner of the dwelling), while located on the above described premises, but not trees, shrubs, plants or lawns.

The insured may apply up to ten per cent (10%) of the amount specified for Item 1 to cover private structures appertaining to the above described premises and located thereon but not structures used for mercantile, manufacturing or farming purposes.†

* As recommended by Insurance Executives Association.

The Insured may apply up to ten per cent (10%) of the amount specified for Item 1 to cover rental value as defined in Item 8, but not exceeding one-twelfth (1/12) of said ten per cent (10%) for each month the above described dwelling or appurtenant private structures (except those used for mercantile, manufacturing or farming purposes) or parts thereof are untenantable.†

*Item 2. $........................ON household and personal property usual or incidental to the occupancy of the premises as a dwelling (except aircraft, motor vehicles and boats other than rowboats and canoes), including household and personal property purchased under an installment plan and usual or incidental to a dwelling, belonging to the Insured or for which the Insured may be liable or, at the option of the Insured belonging to a member of the family of the Insured or to a servant thereof, while contained in the above described dwelling or appurtenant private structures or while on the above described premises.

The Insured may apply up to ten per cent (10%) of the amount specified for Item 2 to cover property described therein and insured thereby (except rowboats, canoes, animals and pets) belonging to the Insured or any member of the family of, and residing with the Insured, while elsewhere than on the described premises but within the limits of that part of Continental North America included within the United States of America, Alaska, the Dominion of Canada and Newfoundland; however, it is warranted by the Insured that such extension of this insurance shall in no wise inure directly or indirectly to the benefit of any carrier or other bailee.†

The Insured (if not the owner) of the described premises) may apply up to ten per cent (10%) of the amount specified for Item 2 to cover improvements, alterations or additions to the above described dwelling and private structures appertaining thereto (except those used for mercantile, manufacturing or farming purposes).†

Loss, if any, under Item 2 shall be adjusted with the Insured specifically named and shall be payable to him unless other payee is specifically named hereunder.

*Item 3. $........................ON..

DESCRIBE

....

*Item 4. $.......................... ON ....
DESCRIBE

....

*Item 5. $.......................... ON ....
DESCRIBE

....

*Item 6. $.......................... ON ....
DESCRIBE

....

*Item 7. $.......................... On trees, shrubs or plants, except those grown for commercial purposes, on the above described premises, but this Company shall not be liable for more than $.......................... on any one tree, $.......................... on any one shrub, nor $.......................... on any one plant.

*Item 8. $.......................... On the rental value (as hereinafter defined) of dwelling and appurtenant private structures (except those used for mercantile, manufacturing or farming purposes) or parts thereof described in Item 1. The term "rental value" shall mean the fair rental value of the dwelling or appurtenant private structures (except those used for mercantile, manufacturing or farming purposes) whether rented or not for the period of time required with the exercise of due diligence and dispatch to restore the same to a tenantable condition, less such charges and expenses as do not continue.

TOTAL $..........................

***Insurance attaches hereunder only to those items for which an amount is shown in the space provided therefor and not exceeding said amount under such item.**

†It is a condition of this insurance that in the event the Insured elects to apply the 10% optional provisions of Items 1 or 2, this Company shall not be liable for a greater proportion of any loss than would have been the case if similar election were made under optional provisions of all policies covering the same property.

Extended Coverage (Perils of Windstorm, Hail, Explosion, Riot, Riot Attending a Strike, Civil Commotion, Aircraft, Smoke, Vehicles, Except as Hereinafter Provided) : Coverage against the perils indicated in the above caption in accordance with and subject to all the terms and conditions of the Extended Coverage appearing on the reverse side of this form will become effective only in consideration of an additional premium next specifically inserted herein. **Additional premium, $**..

Automatic Reinstatement Clause : The amount of insurance hereunder involved in a loss payment of not more than Two Hundred Fifty Dollars ($250) for this policy shall be automatically reinstated.

Lightning and Electrical Apparatus Clause : Except as herein provided, this policy also covers direct loss caused by lightning (meaning thereby the commonly accepted use of the term "lightning"), whether fire ensues or not. If electrical appliances or devices (including wiring) are covered under this policy, this Company shall not be liable for any electrical injury or disturbance to the said electrical appliances or devices (including wiring) caused by electrical currents artificially generated unless fire ensues, and if fire does ensue this Company shall be liable only for its proportion of loss caused by such ensuing fire.

Inherent Explosion Clause : This policy shall cover direct loss to the property covered caused by explosion occurring in the above described dwelling or appurtenant private structures or in any structure containing property covered hereunder from hazards inherent therein, but this Company shall not be liable for loss by explosion originating within steam boilers, steam pipes, steam turbines, steam engines, fly-wheels.

Fall of Building Clause Waiver : If there be a provision in this policy that if the building or any part thereof fall, except as the result of fire, all insurance by this policy shall immediately cease, such provision is hereby waived. However, it is a condition of this waiver that this Company shall not be liable for loss caused by the fall of any portion of said building from a cause other than the perils insured against hereunder unless fire ensue, and in that event for loss by fire only.

Civil Authority Clause : Insurance under this policy shall include liability for direct loss to the described property caused by acts of destruction executed by order of any civil authority at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy.

Permission Granted : (a) For other insurance; (b) For such use of premises as is usual or incidental to the described occupancy; (c) To be unoccupied or vacant without limit of time only if premises described are located within the corporate limits of a city, town or village having a paid or volunteer fire department; and, (d) To make alterations, additions and repairs and to complete structures in course of construction, and this policy (so far as it applies to building) covers all lumber and materials on the premises or adjacent thereto.

EXTENDED COVERAGE

(Perils of Windstorm, Hail, Explosion, Riot, Riot Attending a Strike, Civil Commotion, Aircraft, Vehicles, Smoke, Except as Hereinafter Provided)

In consideration of the premium for this coverage shown on reverse side hereof, and subject to provisions and stipulations (hereinafter referred to as "provisions") herein and in the policy to which this Extended Coverage is attached, including riders and endorsements thereon, the coverage of this policy is extended to include direct loss by WINDSTORM, HAIL, EXPLOSION, RIOT, RIOT ATTENDING A STRIKE, CIVIL COMMOTION, AIRCRAFT, VEHICLES AND SMOKE.

This Extended Coverage does not increase the amount or amounts of insurance provided in the policy to which it is attached.

If this policy covers on two or more items, the provisions of this Extended Coverage shall apply to each item separately.

Substitution of Terms: In the application of the provisions of this policy, including riders and endorsements (but not this Extended Coverage), to the perils covered by this Extended Coverage, wherever the word "fire" appears there shall be substituted therefor the peril involved or the loss caused thereby, as the case requires.

Fall of Building Clause: The Fall of Building Clause, if any, in the policy to which this Extended Coverage is attached shall not apply when the fall is caused by any of the perils included in this Extended Coverage.

Apportionment Clause: This Company shall not be liable for a greater proportion of any loss from any peril or perils included in this Extended Coverage than (1) the amount of insurance under this policy bears to the whole amount of fire insurance covering the property, whether valid or not and whether collectible or not, and whether or not such other fire insurance covers against the additional peril or perils insured hereunder; (2) nor for a greater proportion than the amount of insurance under this policy bears to the amount of all insurance, whether valid or not and whether collectible or not, covering in any manner such loss; furthermore, if there be insurance other than fire insurance covering any one or more of the perils causing loss hereunder, covering specifically any individual unit of property involved in the loss, only such proportion of the insurance under this policy shall apply to such unit specifically insured, as the value of such unit shall bear to the total value of all the property covered under this policy, whether such other insurance contains a similar clause or not.

Glass Clause: It is expressly stipulated as applicable to all perils included in this Extended Coverage that only such proportion of the insurance under this policy on any building covers on plate, stained, leaded or cathedral glass therein as the value of such glass which is damaged bears to the total value of said building.

War Risk Exclusion Clause: This Company shall not be liable for loss by any of the perils insured against in this Extended Coverage caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power.

Waiver of Policy Provisions: A claim for loss from perils included in this Extended Coverage shall not be barred because building is not on ground owned by the Insured in fee simple, factory operations have ceased, of change of occupancy, of existence of encumbrance, of factory operations at night, nor because of vacancy or unoccupancy.

Provisions Applicable Only to Windstorm and Hail: This Company shall not be liable for loss caused directly or indirectly by (a) frost or cold weather or (b) snowstorm, tidal wave, high water or overflow, whether driven by wind or not.

This Company shall not be liable for loss to the interior of the building or the insured property therein caused, (a) by rain, snow, sand or dust, whether driven by wind or not, unless the building insured or containing the property insured shall

first sustain an actual loss to roof or walls by the direct force of wind or hail and then shall be liable for loss to the interior of the building or the insured property therein as may be caused by rain, snow, sand or dust entering the building through openings in the roof or walls made by direct action of wind or hail or (b) by water from sprinkler equipment or other piping unless such equipment or piping be damaged as a direct result of wind or hail.

Unless liability therefor is assumed in the form attached to this policy, or by endorsement hereon, this Company shall not be liable for damage to the following property: (a) grain, hay, straw or other crops outside of buildings or (b) windmills, windpumps or their towers, cloth awnings, signs, metal smokestacks, temporary or board roof additions, or (c) buildings (or their contents) in process of construction or reconstruction unless entirely enclosed and under roof with all outside doors and windows permanently in place.

Provisions Applicable Only to Explosion: This Company shall not be liable for loss by explosion originating within steam boilers, steam pipes, steam turbines, steam engines, fly-wheels, located in the building(s) insured or in building(s) containing the property insured.

Any other explosion clause made a part of this policy is superseded by this Extended Coverage.

Provisions Applicable Only to Riot, Riot Attending a Strike and Civil Commotion: Loss by riot, riot attending a strike or civil commotion shall include direct loss by acts of striking employees of the owner or tenant(s) of the described building(s) while occupied by said striking employees and shall also include direct loss from pillage and looting occurring during and at the immediate place of a riot, riot attending a strike or civil commotion. This Company shall not be liable, however, for loss resulting from damage to or destruction of the described property owing to change in temperature or interruption of operations resulting from riot or strike or occupancy by striking employees or civil commotion, whether or not such loss, due to change in temperature or interruption of operations, is covered by this policy as to other perils.

Provisions Applicable Only to Loss by Aircraft and Vehicles: Loss by "aircraft" includes direct loss by objects falling therefrom. The term "vehicles," as used in this Extended Coverage, means vehicles running on land or tracks. This Company shall not be liable, however, for loss (a) by any vehicle owned or operated by the Insured or by any tenant of the described premises; (b) to aircraft or vehicles including contents other than stocks of aircraft or vehicles in process of manufacture or for sale; (c) to fences, driveways, sidewalks or lawns.

Provisions Applicable to Smoke: The term "smoke" as used in this Extended Coverage means only smoke due to a sudden, unusual and faulty operation of any heating or cooking unit, only when such unit is connected to a chimney by a smoke pipe, and while in or on the premises described in this policy, excluding, however, smoke from fireplaces or industrial apparatus.

Provisions Applicable Only when this Extended Coverage is attached to a Policy Covering Business Interruption (Use and Occupancy), Extra Expense, Rents, Leasehold Interest or Profits and Commissions: When this Extended Coverage is attached to a policy covering Business Interruption (Use and Occupancy), Extra Expense, Rents, Leasehold Interest, Profits and Commissions, the term "direct," as applied to loss, means loss, as limited and conditioned in such policy, resulting from direct loss to described property from perils insured against; and, while the business of the owner or tenant(s) of the described building(s) is interrupted by a strike at the described location, this Company shall not be liable for any loss owing to interference by any person(s) with rebuilding, repairing or replacing the property damaged or destroyed or with the resumption or continuation of business.

APPENDIX III

SPECIAL HAZARD FORM

Standard Forms Bureau Form 516 (Dec. 1927)

SPECIAL HAZARD FORM

On the following described property, all only while situate...............
....
....
....

This policy being for \$......covers....../........ths of each of the amounts specified and inserted in the blanks immediately preceding the following item:

*1. \$......On the........building occupied as..........and known
(State nature of occupancy)
as..

*2. \$......On equipment, while contained in above described building.

*3. \$......On stock, while contained in above described building.

*4. \$......On machine shop and/or foundry patterns, while contained in above described building.

*5. \$......On the........building occupied as..........and known
(State nature of occupancy)
as..

*6. \$......On equipment, while contained in last above described building.

*7. \$......On stock, while contained in last above described building.

*8. \$......On machine shop and/or foundry patterns, while contained in last above described building.

*9. \$......On the........building occupied as..........and known
(State nature of occupancy)
as..

*10. \$......On equipment, while contained in last above described building.

*11. \$......On stock, while contained in last above described building.

*12. \$......On machine shop and/or foundry patterns, while contained in last above described building.

*13. \$......On the........building occupied as..........and known
(State nature of occupancy)
as..

*14. \$......On equipment, while contained in last above described building.

*15. \$......On stock, while contained in last above described building.

*16. $......On machine shop and/or foundry patterns, while contained in last above described building.

*17. $......On..
....

*18. $......On..
....

***No insurance attaches under any of the above items unless a certain amount is specified and inserted in the blank immediately preceding the item.**

"Restriction in Case of Specific Insurance." No article or piece of personal property separately insured for a specific amount under this, or any other policy, is covered by this policy except for such specific amount, if any, named herein; nor shall this company be liable for loss to personal property of others for which the insured is liable by law or shall have specifically assumed liability, on which insurance is carried by or in the name of others than the insured named in this policy.

Other insurance permitted.

Loss if any, subject however to all the terms and conditions of this policy, payable to..

The provisions printed on the back of this form are hereby referred to and made a part hereof.

Attached to Policy No............of the..............................
NAME OF COMPANY

Agency at........................, Dated..............................

INSURANCE MAP SPECIAL RATE

Sheet............ Page............

Block........... ....

No............. Line............ Agent.

For Other Provisions See Reverse Side of This Rider

(Reverse)

Provisions Referred to in and Made Part of This Rider (No. 516)

The words "Building" "Equipment" "Stock" wherever used herein shall be construed to cover as follows:

"Building." On building and its additions (if any) of like construction communicating and in contact therewith, including foundations and capping and piling immediately thereunder, sidewalks, plumbing, electrical wiring and stationary heating and lighting apparatus and fixtures; also on all permanent fixtures, awnings, wall and ceiling decorations and frescoes, stationary scales, machinery and elevators and equipment belonging to and constituting a part of said building; on materials contained therein and/or on the ground within one hundred feet thereof for use in constructing additions or in making alterations or repairs to the building; and on platforms, trestles, gangways and chutes attached thereto and located on the above described premises, provided, however, that if same connect with any other building, then this insurance, as respects such platforms, trestles, gangways and chutes, shall cover only such portion thereof situate on the above

described premises, as lies between said insured building and a point midway between it and such other building.

"**Equipment.**" On office and other furniture and fixtures; on machinery and its foundations and appurtenances, and millwright work pertaining thereto not belonging to or constituting a part of building; on dies, implements, models, patterns other than machine shop or foundry patterns, pictures, scientific apparatus, signs, tools and appliances of every description used or useful in the business of insured; and on materials, extra parts and supplies, provided materials, extra parts and supplies be for equipment or maintenance of property described under this item and not included in "building" as above defined or in "stock" as below defined; all only while contained in, on, or attached to "building" as above defined, and in or on cars and vehicles while within 300 feet thereof.

"**Stock.**" On stock incident to the business, manufactured, in process of manufacture, and on all materials and supplies used or useful in the business of insured and not included in "building" "equipment" as above defined, including packages, labels, cases, boxes and all wrapping and packing materials, being the property of insured or sold but not removed; and (provided the insured shall be liable by law for loss or damage thereto or shall have specifically assumed liability therefor), this insurance shall also cover merchandise held in trust, or on commission, or left for storage or repairs, but loss thereon shall be adjusted with and payable to the insured named in this policy; all only while contained in, on, or attached to "building" as above defined, and in or on cars and vehicles while within 300 feet thereof.

"**Sidewalk Clause.**" It is understood that property above described is also covered under its respective items, while on and/or under sidewalks, platforms, alleyways and open space pertaining to above described building, provided such property be located within 25 feet of said building and be not otherwise specifically insured.

"**Shutdown.**" Subject to the conditions (if any) of this policy regarding the maintenance of watchmen, permission is granted for the within described property to cease to be operated for a period of sixty days at any one time.

"**Railroad Subrogation Waiver.**" It is understood and agreed that any release from liability in a written contract entered into, prior to loss hereunder, by the insured with a railroad company as a condition of obtaining side track or other accommodations, shall in no way affect this policy or the rights of the insured to recover hereunder.

"**Permits.**" Permission granted to make alteration or repairs to the above described building without limit of time, and to build additions, and if of like construction and communicating and in contact therewith, this policy shall cover on or in same under its respective items pertaining thereto; permission also granted to do such work in said building as the nature of the occupancy may require; to work at any and all times; and, when not in violation of law or ordinance, to generate illuminating gas or vapor, and to keep and use the necessary quantities of all articles, things and materials incidental to the business conducted on the premises described herein.

"**Lightning Clause.**" This policy shall cover any direct loss or damage by lightning (meaning thereby the commonly accepted use of the term "lightning" and in no case to include loss or damage by cyclone, tornado or windstorm) not exceeding the sum insured nor the interest of the insured in the property, and subject in all other respects to the terms and conditions of this policy; Provided, however, that if there shall be any other insurance on said property this company shall be liable only pro rata with such other insurance for any direct loss by lightning whether such other insurance be against direct loss by lightning or not.

"Electrical Exemption Clause." If dynamos, wiring, lamps, motors, switches or other electrical appliances or devices are insured by this policy, this insurance shall not cover any immediate loss or damage to dynamos, exciters, lamps, motors, switches, or any other apparatus for generating, utilizing, testing, regulating, or distributing electricity, caused directly by electric currents therein whether artificial or natural, including lightning.

APPENDIX IV

N. Y. S. FORM NO. 355 (Edition Sept. '43)

PERMIT FOR VACANCY OR UNOCCUPANCY

In consideration of $ ...... additional premium, permission is hereby given for the building described in this policy to be unoccupied and/or vacant for a period of .... from the .... day of .... 19 .. , to the .... day of .... 19 ......, at 12:00 o'clock noon.

Attached to and forming part of Policy No............ of the ....

Insurance Company, issued at its............ N. Y., Agency.

Dated............ 19............ Agent.

FORM NO. 355
(Edition Sept. '43)

APPENDIX V

NEW YORK STANDARD MORTGAGEE CLAUSE

N. Y. S. FORM NO. 339
(Edition June, '43)

(M) **NEW YORK STANDARD MORTGAGEE CLAUSE** (M)

(FOR USE IN CONNECTION WITH FIRST MORTGAGE INTEREST ON REAL ESTATE)

Loss or damage, if any, under this policy, shall be payable to ______________________________

____

____

____

______________________________________ as ______________ mortgagee (or trustee), as interest may appear, and this insurance, as to the interest of the mortgagee (or trustee) only therein, shall not be invalidated by any act or neglect of the mortgagor or owner of the within described property, nor by any foreclosure or other proceedings or notice of sale relating to the property, nor by any change in the title or ownership of the property, nor by the occupation of the premises for purposes more hazardous than are permitted by this policy; provided, that in case the mortgagor or owner shall neglect to pay any premium due under this policy, the mortgagee (or trustee) shall, on demand, pay the same.

Provided, also, that the mortgagee (or trustee) shall notify this Company of any change of ownership or occupancy or increase of hazard which shall come to the knowledge of said mortgagee (or trustee), and unless permitted by this policy, it shall be noted thereon and the mortgagee (or trustee) shall, on demand, pay the premium for such increased hazard for the term of the use thereof; otherwise this policy shall be null and void.

This Company reserves the right to cancel this policy at any time as provided by its terms, but in such case this policy shall continue in force for the benefit only of the mortgagee (or trustee) for ten days after notice to the mortgagee (or trustee) of such cancellation and shall then cease, and this Company shall have the right, on like notice, to cancel this agreement

Whenever this Company shall pay the mortgagee (or trustee) any sum for loss or damage under this policy and shall claim that, as to the mortgagor or owner, no liability therefor existed, this Company shall, to the extent of such payment, be thereupon legally subrogated to all the rights of the party to whom such payment shall be made, under all securities held as collateral to the mortgage debt, or may, at its option, pay to the mortgagee (or trustee) the whole principal due or to grow due on the mortgage with interest, and shall thereupon receive a full assignment and transfer of the mortgage and of all such other securities; but no subrogation shall impair the right of the mortgagee (or trustee) to recover the full amount of ______________ claim.

Attached to and forming part of Policy No. ______________ of the ______________________

Insurance Company, issued at its ______________________ N. Y., Agency. ______________

Dated ______________________, 19____ ______________________________ Agent.

FORM NO. 339
(Edition June, '43)

APPENDIX VI

PRO RATA DISTRIBUTION CLAUSE

SUBURBAN DIVISION
N. Y. F. I. R. O.

FORM NO. 341
January, 1929

PRO RATA DISTRIBUTION CLAUSE

It is a condition of this contract that the amount covered hereunder shall attach in or on each building, shed and other structure and/or place in that proportion of the amount thereby covered that the value of the property covered by this policy in or on each said building, shed and other structure and/or place shall bear to the value of all of the property described herein.

Attached to and forming part of Policy No.__________ of the____________________

____________________issued at its____________________N. Y., Agency

Dated____________________ ____________________Agent.

APPENDIX VII

FORM NO. 349
(Edition January '29)

CLEAR SPACE CLAUSE

It is warranted by the insured that a clear space of not less than . . . - - feet shall be maintained by the insured between the property hereby covered and any manufacturing establishment, and that such space shall not be used for any purpose except for transportation purposes across such clear space

Attached to and forming part of Policy No .... of the ....

Insurance Company, issued at its .... N. Y., Agency

Dated .... 19 .... Agent

APPENDIX VIII

N. Y. S.

FORM NO. 510
(Edition June '43)

AUTOMATIC SPRINKLER CLAUSE NO. 1

This policy being written at a rate based on the protection of the premises by the sprinkler system, it is a condition of this policy that, in so far as the sprinkler system and water supply therefor are under the control of the insured, due diligence shall be used by the insured to maintain them in complete working order and that no change shall be made in said system or in the water supply therefor unless immediate notification is given to New York Fire Insurance Rating Organization Permission, however, is hereby given in case of break, leakage, or the opening of sprinkler heads, to shut off the water from so much of the sprinkler system as may be imperatively necessary, it being a condition of this policy that New York Fire Insurance Rating Organization will be immediately notified and the protection restored as promptly as possible.

Attached to and forming part of Policy No........ of the........

Insurance Company, issued at its........ N. Y., Agency.

Dated........ 19 .. .. Agent

FORM NO. 510
(Edition June '43)

APPENDIX IX

INVENTORY AND IRON SAFE CLAUSE

STANDARD FORMS BUREAU FORM 306 (MAY 1930)

INVENTORY AND IRON SAFE CLAUSE.

(REQUIREMENT TO KEEP BOOKS AND INVENTORY)

COMMENCEMENT OF POLICY	EXPIRATION OF POLICY	AMOUNT INSURED	OLD RATE	NEW RATE	RETURN PREMIUM

It is made a condition of this insurance:

(1) That the insured under this policy shall take an inventory of the stock of merchandise hereby insured at least once every twelve months during the term of this policy, and unless such inventory has been taken within one year prior to the date of this policy, one shall be taken in detail within thirty (30) days thereafter.

(2) That the insured shall keep a set of books showing a complete record of business transacted, including all purchases and sales both for cash and for credit.

(3) That the insured shall keep such books and inventory securely locked in a fireproof safe at night, and at all times when the store mentioned in the within policy is not actually open for business, or in some secure place not exposed to a fire which would destroy the building where such business is carried on.

(4) That in case of loss the insured shall produce such books and last inventory, and failing so to do, the insurance under this policy on stock of merchandise shall be rendered null and void.

Attached to Policy No. .... of the ....
NAME OF COMPANY

Issued to........................

Agency at .... Dated........................

TRADE MARK STANDARD REG. U.S. PAT. OFF
306
MAY 1930

....
Agent.

APPENDIX X

THREE-FOURTHS VALUE CLAUSE

STANDARD FORMS BUREAU FORM 546 (MAY 1933)

THREE-FOURTHS VALUE CLAUSE

It is a condition of this insurance that, in event of loss under the......................item of this policy, this company shall not be liable thereunder for an amount greater than three-fourths of the actual cash value of the property covered by said item of this policy at the time of such loss; and in case of other insurance, whether valid or not, then for only its pro rata proportion of such three-fourths value. If more than one item be named herein, this clause shall apply to each such item separately.

Attached to Policy No........................ of the........................
NAME OF COMPANY

Issued to........................

Agency at........................ Dated........................

TRADE MARK STANDARD REG. U.S. PAT. OFF
546
MAY 1933

....
Agent.

APPENDIX XI

UNIFORM STANDARD (New Policy) **FORM NO. 193-L**
(Edition Mar. '44)

USE AND OCCUPANCY

Standard Contribution Form for Manufacturing or Mining Risks

Attached to and forming part of Policy No...
of the...
NAME OF INSURANCE COMPANY
issued at its.....................................Agency. Dated..............................19.......
CITY OR TOWN STATE
This policy being for $...................covers its pro rata proportion of and on the following amounts:

This policy covers, subject to all its provisions and stipulations, the Use and Occupancy of the property described as follows:

....

....

occupied by the Insured as..
situated...

....

....
HERE GIVE STREET NUMBER, OR LOT OR BLOCK NUMBER OR TOWNSHIP, SECTION AND RANGE
City or Town of...State of...............................

If the building(s) and/or structures and/or machinery and equipment and/or Raw Stock contained therein (Strike out "and/or Raw Stock," if rate used does not contemplate raw stock coverage) be destroyed or damaged by fire occurring during the term of this policy so as to necessitate a total or partial suspension of business, this Company shall be liable under this policy for the ACTUAL LOSS SUSTAINED, for not exceeding such length of time as would be required with the exercise of due diligence and dispatch, to rebuild, repair or replace such part of the property described as covered by this policy as has been destroyed or damaged, commencing with the date of the fire and not limited by the date of expiration of this policy, to wit:—

Item I. $.......................On (a) the net profit which is thereby prevented from being earned and
(b) such charges and other expenses, including salaries of officers—executives—department managers—employees under contract and other important employees, as must necessarily continue during a total or partial suspension of business,

to the extent only that such charges and and expenses would have been earned had no fire occurred.

This Item (I) covers expense of necessary heat, light or power, the cost of which is prevented from being earned during the time of total or partial suspension of business caused by fire. This Item (I) **does not cover** any portion of the Insured's ordinary payroll described in Item II.

Item II. $......................On the Insured's entire ordinary payroll for a period of time of not in excess of 90 consecutive days immediately following loss or damage by fire which may continue during a total or partial suspension of business, covering only to the extent necessary to resume the normal business of the Insured with the same quality of service which existed immediately preceding the fire, and which would have been earned had no fire occurred.

This Item (II) **does not cover** any portion of salaries described in Item (I).

Liability under this Item (II) including time, if any, to replace stock in process and/or raw stock which may be damaged or destroyed shall not extend for more than 90 days after loss or damage by fire.

Items I and II cover such expenses as are necessarily incurred for the purpose of reducing any loss under this policy, not exceeding, however, the amount by which the loss covered is thereby reduced, it being a condition that if this policy covers Use and Occupancy loss described under both Items (I and II), the said expenses shall be apportioned to these Items in the proportion that the reduction in amount of liability of this Company under each Item bears to the total reduction of liability under both Items.

However, if this policy covers Use and Occupancy loss described under **one** of these two Items (I and II) **only**, and there be any other insurance covering the Use and Occupancy loss described under the other Item, the proportion of said expenses assumed under the Item covered by this Company shall not exceed that proportion of said expenses that the amount of reduction of liability of this Company under the covered Item bears to the total reduction of liability under both Items.

The amount of net profit and/or charges and expenses covered under Item I or Item II, shall be determined, whether for the purpose of ascertaining the amount of loss sustained or for the application of the Contribution Clause, by giving due consideration to the experience of the business before the fire and the probable experience thereafter.

Contribution Clause: In consideration of the rate and form under which Items I and II of this policy are written, this Company shall be liable, in

event of loss, for no greater proportion thereof than the amount hereby covered under each respective Item, bears to,

(a) Under Item I,....................% of the sum of the annual net profits and
INSERT 100 OR 80
of the annual amount of all charges and other expenses (except the expense of the Insured's entire ordinary payroll, the expense of heat, light and power and the expense incurred for purpose of reducing any loss under this policy) that would have been earned (had no fire occurred) during the twelve (12) months immediately following loss or damage by fire, whether or not said charges and other expenses necessarily continue during a total or partial suspension of business.

(b) Under Item II,....................% of the Insured's entire ordinary payroll,
INSERT 100 OR 80
excluding only salaries described in Item I, which would have been earned (had no fire occurred) during the ninety (90) consecutive days immediately following loss or damage by fire.

Work and Materials Clause: Permission granted for such use of the premises as is usual and incidental in the business, as conducted therein, of..
STATE KIND OF BUSINESS
and to keep and use all articles and materials usual and incidental to said business, in such quantities as the exigencies of the business require.

SPECIAL CONDITIONS APPLICABLE TO MINING RISKS

The following conditions (a) and (b) are applicable only to Mining Risks:

(a) This insurance does not extend to cover any loss by reason of fire in mine or mines or by reason of the disturbance of any property underground, unless by reason of such fire any superstructure above ground may be damaged or destroyed, and then only for the loss that would be occasioned by the time it would take to repair or to replace such structure or structures.

(b) This policy applies only to the buildings and machinery that contribute to the production of the mining plant, and all storehouses and contents, commissaries and contents, and dwellings and contents, are excluded unless specifically provided for herein.

THE PROVISIONS PRINTED ON THE BACK OF THIS FORM ARE HEREBY REFERRED TO AND MADE A PART HEREOF.

KY., MO., NEBR., NO. DAK.,
OHIO, SO. DAK., TENN., COLO., WYO., N. MEX..................................

NOTE TO AGENTS: This form may be used on either, a Fire, or a Windstorm, or a Combined Fire and Windstorm, Policy.

Sprinkled Risks.—If policy covers risk equipped with automatic sprinklers, the Automatic Sprinkler Clause must be attached.

Watchman's Clause.—If policy covers risk where credit has been allowed for watchman's service, the Watchman's Clause must be attached.

PROVISIONS PRINTED ON THE BACK OF THE FORM

Definitions, "Raw Stock," "Stock-in-Process," "Finished Stock," "Day," "Normal":

(a) The term "Raw Stock," wherever used in this contract shall be construed to mean materials and supplies usual to the Insured's business in the state in which the Insured received them.
(b) The term "Stock-in-Process," wherever used in this contract shall be construed to mean "Raw Stock" which has undergone any aging, seasoning, mechanical or other process of manufacture at the described location, but which has not become "finished stock."
(c) The term "Finished Stock," wherever used in this contract shall be construed to mean any stock which in the ordinary course of the Insured's business is ready for packing, shipment or sale.
(d) The word "Day," however modified, wherever used in this contract shall be construed to mean twenty-four consecutive hours.
(e) The word "Normal," however modified, wherever used in this contract shall be construed to mean the condition that would have existed had no fire occurred.

Stock-in-Process: This policy, subject to all its provisions and stipulations, and without increasing the amount of said policy, shall include such additional time, if any, not exceeding thirty (30) business days, as may be required with the exercise of due diligence and dispatch to replace and/or restore any stock-in-process damaged or destroyed, while in the described buildings, or in the open on premises described, and/or to restore said stock-in-process to the same state of manufacture in which it stood at the time of the fire.

Raw Stock: If liability for suspension of business due to damage to or destruction of raw stock is specifically assumed hereunder, such liability shall be limited to that period of time for which the damaged or destroyed raw stock would have made operations possible.

Resumption of Operation and Use of Other Property: As soon as practicable after any loss, the Insured shall resume complete or partial operation of the property herein described and shall make use of other property, if obtainable, if by so doing the amount of loss hereunder will be reduced, and in the event of the loss being so reduced such reduction shall be taken into account in arriving at the amount of the loss hereunder.

Surplus Equipment and Supplies: Surplus machinery or duplicate parts thereof, equipment or supplies, and surplus or reserve raw stock or stock-in-process, which may be owned, controlled or used by the Insured, shall, in the event of loss, be used in placing the property in condition for continuing or resuming business.

Special Exclusions: This Company shall not be liable for any loss resulting from damage to or destruction of finished stock, nor for the time required to reproduce any finished stock which may be damaged or destroyed, nor for any loss which may be occasioned by any ordinance or law regulating construction or repair of buildings, nor by suspension, lapse or cancellation of any lease or license, contract or order, nor for any other consequential loss, nor for any remote loss.

Limit of Liability: The liability under the respective Items of this policy shall not exceed the amount of insurance thereunder, nor a greater propor-

tion of any loss than the insurance thereunder shall bear to all insurance, whether valid or not, and whether collectible or not, covering in any manner the loss insured against by the respective Items of this policy.

Appraisal Clause and General Policy Provisions: In case the Insured and this Company are unable to agree as to the value of the subject of this insurance, or the amount of loss thereon, or the time necessary to rebuild, repair or replace the premises or buildings or structures or machinery and equipment, or stock if liability due to damage to or destruction of stock be included, the same shall be determined by appraisal in the manner provided by this policy. The provisions and stipulations of this policy shall govern in all matters pertaining to this insurance except as herein otherwise stipulated.

Alterations and Repairs Permit: Permission granted to make alterations, improvements and repairs to any building herein described, and to construct additions or sheds which attach to and communicate with such building, and this policy is extended to cover the Use and Occupancy value of such attached and communicating additions and sheds to said building; but if any building herein described is protected by automatic sprinklers, this permit shall not be held to include the reconstruction or the enlargement of any building so protected, without the consent of this Company in writing. This permit does not waive or modify any of the terms or conditions of the Automatic Sprinkler Clause (if any) attached to this policy.

Automatic Reinstatement Clause: It is a condition of this insurance that in the event of any loss payment under this policy not exceeding One Hundred Dollars ($100) the amount of insurance under this policy shall not be reduced by such payment.

Interruption by Civil Authority: Notwithstanding anything to the contrary herein, this Company shall be liable for actual loss sustained, as covered hereunder, during the period of time, not exceeding two weeks, while access to the premises described is prohibited by order of civil authority, but only when such order is given as a direct result of fire in the vicinity of said premises.

Electrical Apparatus Clause (This Clause Void as to Windstorm Insurance): This Company shall not be liable for Use and Occupancy loss resulting from electrical injury, disturbance or damage to electrical apparatus, equipment, appliances or devices caused by electrical currents artificially generated, unless fire ensues, but if fire does ensue, then this Company shall be liable for its proportion of Use and Occupancy loss caused by such ensuing fire.

When this form is attached to a policy covering the perils of windstorm and hail, this Company shall not be liable for any Use and Occupancy loss resulting from damage to or destruction of metal smokestacks by windstorm or hail, unless otherwise provided for by endorsement hereon and additional premium paid therefor.

When attached to a policy covering the perils of windstorm and hail, wherever the word "fire" appears in this form, it shall be construed to mean windstorm or hail.

Form No. 193-L (Edition Mar. '44)

APPENDIX XII

SHORT-RATE TABLE

Time policy in force	Policy earns if written for term of 1 yr.	Time policy in force	Policy earns if written for a term of 3 yr. for 2 annuals	3 yr. for 2½ annuals	5 yr. for 3 annuals	5 yr. for 4 annuals
	1 Yr. Prem.		3 Yr. Prem.	3 Yr. Prem.	5 Yr. Prem.	5 Yr. Prem.
1 Day	2% of "	1 Month	10% of "	8% of "	7% of "	5% of "
2	4% of "	2	15% of "	12% of "	10% of "	8% of "
3	5% of "	3	20% of "	16% of "	13% of "	10% of "
4	6% of "	4	25% of "	20% of "	17% of "	13% of "
5	7% of "	5	30% of "	24% of "	20% of "	15% of "
6	8% of "	6	35% of "	28% of "	23% of "	18% of "
7	9% of "	7	38% of "	30% of "	25% of "	19% of "
8	9% of "	8	40% of "	32% of "	27% of "	20% of "
9	10% of "	9	43% of "	34% of "	28% of "	21% of "
10	10% of "	10	45% of "	36% of "	30% of "	22% of "
11	11% of "	11	48% of "	38% of "	32% of "	24% of "
12	12% of "	12	50% of "	40% of "	33% of "	25% of "
13	13% of "	13	53% of "	43% of "	35% of "	27% of "
14	13% of "	14	57% of "	45% of "	38% of "	28% of "
15	14% of "	15	60% of "	48% of "	40% of "	30% of "
16	14% of "	16	63% of "	50% of "	42% of "	31% of "
17	15% of "	17	67% of "	53% of "	45% of "	33% of "
18	16% of "	18	70% of "	55% of "	47% of "	34% of "
19	16% of "	19	72% of "	58% of "	48% of "	36% of "
20	17% of "	20	74% of "	60% of "	49% of "	38% of "
25	19% of "	21	75% of "	63% of "	50% of "	39% of "
30–1 Mo.	20% of "	22	77% of "	65% of "	51% of "	41% of "
35	23% of "	23	79% of "	68% of "	53% of "	42% of "
40	26% of "	24	80% of "	70% of "	54% of "	44% of "
45	27% of "	25	82% of "	73% of "	55% of "	45% of "
50	28% of "	26	84% of "	75% of "	56% of "	47% of "
55	29% of "	27	85% of "	78% of "	57% of "	48% of "
60–2 Mo.	30% of "	28	87% of "	80% of "	58% of "	50% of "
65	33% of "	29	89% of "	83% of "	59% of "	52% of "
70	36% of "	30	90% of "	85% of "	60% of "	53% of "
75	37% of "	31	92% of "	88% of "	61% of "	55% of "
80	38% of "	32	94% of "	90% of "	63% of "	56% of "
85	39% of "	33	95% of "	93% of "	64% of "	58% of "
90–3 Mo.	40% of "	34	97% of "	95% of "	65% of "	59% of "
105	46% of "	35	99% of "	98% of "	66% of "	61% of "
120–4 Mo.	50% of "	36	100% of "	100% of "	67% of "	63% of "
135	56% of "	37				64% of "
150–5 Mo.	60% of "	38				66% of "
165	66% of "	39				67% of "
180–6 Mo.	70% of "	40				69% of "
195	73% of "	41				70% of "
210–7 Mo.	75% of "	42			80% of "	72% of "
225	78% of "	43				73% of "
240–8 Mo.	80% of "	44				75% of "
255	83% of "	45				77% of "

SHORT-RATE TABLE.—(*Continued*)

Time policy in force	Policy earns if written for term of 1 yr.	Time policy in force	Policy earns if written for a term of 3 yr. for 2 annuals	3 yr. for $2\frac{1}{2}$ annuals	5 yr. for 3 annuals	5 yr. for 4 annuals
	1 Yr. Prem.		3 Yr. Prem.	3 Yr. Prem.	5 Yr. Prem.	5 Yr. Prem.
270–9 Mo...	85 % of "	46				78 % of "
285.........	88 % of "	47				80 % of "
300–10 Mo..	90 % of "	48			90 % of "	81 % of "
315.........	93 % of "	49				83 % of "
330–11 Mo..	95 % of "	50				84 % of "
360–12 Mo..	100 % of "	51				86 % of "
		52				88 % of "
		53				89 % of "
		54			95 % of "	91 % of "
		55				92 % of "
		56				94 % of "
		57				95 % of "
		58				97 % of "
		59				98 % of "
		60			100 % of "	100 % of "

Instructions

When a policy is cancelled at the request of the *insured*, the earned premium is computed on a short-rate basis.

For any item not appearing in the above Short-rate Table the charge for the next longer term shall be used, *i.e.*, if the policy has been in force, say, 32 days use the percentage given for 35 days which is the next longer term shown in the table.

Procedure to be followed in order to ascertain the *short rate* earned premium when cancelling policies written for *one-year term.*

Amount of policy, \$1,000 Rate, \$1 Annual premium, \$10 Policy term, one year. Policy commencement date, February 1, 1943. Policy expiration date, February 1, 1944. Policy cancelled short rate, May 17, 1943, was in effect 105 days and would, according to the above short rate table, earn 46 % of the annual premium of \$10 or \$4.60.

The same procedure is followed when cancelling policies written for *three- or five-year terms* using the proper percentages found under the respective headings.

APPENDIX XIII

FORM OF MARINE POLICY

SPECIAL CARGO POLICY FORM

By Insurance Company. **No.**

ON ACCOUNT OF

In case of loss to be paid in funds current in the United States, or in the City of New York to

Do make Insurance and cause **to be insured, lost or not lost, at and from**

Sum Insured.
$

If there be one at the place such proofs are taken.

upon all kinds of lawful goods and merchandises, laden or to be laden on board the good..........................called the.. whereof is master for this present voyage. or whoever else shall go for master in the said vessel, or by whatever other name or names the said vessel, or the master thereof, is or shall be named or called.

Beginning the adventure upon the said goods and merchandises, from and immediately following the loading thereof on board of the said vessel, at as aforesaid, and so shall continue and endure until the said goods and merchandises shall be safely landed at as aforesaid. AND it shall and may be lawful for the said vessel, in her voyage, to proceed and sail to, touch and stay at, any ports or places, if thereunto obliged by stress of weather or other unavoidable accident, without prejudice to this insurance. The said goods and merchandises, hereby insured, are valued (premium included) at

Touching the adventures and perils which the said Insurance Company is contented to bear, and takes upon itself in this voyage, they are of the *seas, men-of-war, fires, enemies, pirates, rovers, thieves, jettisons, letters of mart and countermart, reprisals, takings at sea, arrests, restraints and detainments of all kings, princes or people, of what nation, condition or quality soever, barratry of the master and mariners*, and all other perils, losses and misfortunes, that have or shall come to the hurt, detriment or damage of the said goods and merchandises, or any part thereof. AND in case of any loss or misfortune, it shall be lawful and necessary to and for the assured, factors, servants and assigns, to sue, labor, and travel for, in and about the defence, safeguard and recovery of the said goods and merchandises, or any part thereof, without prejudice to this insurance; nor shall the acts of the insured or insurers, in recovering, saving and preserving the property insured, in case of disaster be considered a waiver or an acceptance of an abandonment; to the charges whereof, the said Insurance Company will contribute according to the rate and quantity of the sum herein insured, having been paid the consideration for this insurance, by the assured or assigns, at and after the rate of

And in case of loss, such loss to be paid in thirty days after proof of loss, and proof of interest in the said (the amount of the Note given for the premium, if unpaid, being first deducted), but no partial loss or particular average shall in any case be paid, unless amounting to *five per cent.* PROVIDED ALWAYS, and it is hereby further agreed, That if the said assured shall have made any other assurance upon the premises aforesaid, prior in day of date to this policy, then the said

INSURANCE COMPANY shall be answerable only for so much as the amount of such prior assurance may be deficient towards fully covering the premises hereby assured; and the said INSURANCE COMPANY shall return the premium upon so much of the sum by them assured, as they shall be by such prior assurance exonerated from. AND in case of any insurance upon the said premises, subsequent in day of date to this policy, the said INSURANCE COMPANY shall nevertheless be answerable for the full extent of the sum by them subscribed hereto, without right to claim contribution from such subsequent assurers, and shall accordingly be entitled to retain the premium by them received, in the same manner as if no such subsequent assurance had been made. Other insurance upon the premises aforesaid, of date the same day as this policy, shall be deemed simultaneous herewith; and the said INSURANCE COMPANY shall not be liable for more than a ratable contribution in the proportion of the sum by them insured to the aggregate of such simultaneous insurance. IT IS ALSO AGREED, that the property be warranted by the assured free from any charge, damage or loss, which may arise in consequence of a seizure or detention, for or on account of any illicit or prohibited trade, or any trade in articles contraband of war.

Warranted not to abandon in case of capture, seizure, or detention, until after condemnation of the property insured; nor until ninety days after notice of said condemnation is given to this Company. Also warranted not to abandon in case of blockade, and free from any expense in consequence of capture, seizure, detention or blockade, but in the event of blockade, to be at liberty to proceed to an open port and there end the voyage.

Proof of loss to be authenticated by the Agent of the Company.

In witness whereof, the President or Vice-President of the said **Insurance Company** hath hereunto subscribed his name, and the sum insured, and caused the same to be attested by their Secretary, in **New-York**, the day of one thousand nine hundred and

Memorandum. It is also agreed, that bar, bundle, rod, hoop and sheet iron, wire of all kinds, tin plates, steel, madder, sumac, wicker-ware and willow, (manufactured or otherwise), salt, grain of all kinds, tobacco, indian meal, fruits, (whether preserved or otherwise), cheese, dry fish, hay, vegetables and roots, rags, hempen yarn, bags, cotton bagging and other articles used for bags or bagging, pleasure carriages, household furniture, skins and hides, musical instruments, looking-glasses, and all other articles that are perishable in their own nature, are warranted by the assured free from average, unless general; hemp, tobacco stems, matting and cassia, except in boxes, free from average under *twenty per cent.* unless general; and sugar, flax, flax-seed and bread, are warranted by the assured free from average under *seven per cent.* unless general; and coffee in bags or bulk, pepper in bags or bulk, and rice, free from average under *ten per cent.*, unless general.

Warranted by the insured free from damage or injury, from dampness, change of flavor, or being spotted, discolored, musty or mouldy, except caused by actual contact of sea water with the articles damaged, occasioned by sea perils. In case of partial loss by sea damage to dry goods, cutlery or other hardware, the loss shall be ascertained by a separation and sale of the portion only of the contents of the packages so damaged, and not otherwise; and the same practice shall obtain as to all other merchandise as far as practicable. Not liable for leakage on molasses or other liquids, unless occasioned by stranding or collision with another vessel.

If the voyage aforesaid shall have been begun and shall have terminated before the date of this policy, then there shall be no return of premium on account of such termination of the voyage.

In all cases of return of premium, in whole or in part, *one-half per cent.*, upon the sum insured, is to be retained by the assurers.

Premium

$

Secretary.

President.

APPENDIX XIV

AMERICAN INSTITUTE WAREHOUSE TO WAREHOUSE CLAUSE

(July, 1941)

This insurance attaches from the time the goods leave the Warehouse and/or Store at the place named in the policy for the commencement of the transit and continues during the ordinary course of transit, including customary transshipment if any, until the goods are discharged overside from the overseas vessel at the final port. Thereafter the insurance continues whilst the goods are in transit and/or awaiting transit until delivered to final warehouse at the destination named in the policy or until the expiry of 15 days (or 30 days if the destination to which the goods are insured is outside the limits of the port) whichever shall first occur. The time limits referred to above to be reckoned from midnight of the day on which the discharge overside of the goods hereby insured from the overseas vessel is completed. Held covered at a premium to be arranged in the event of transshipment, if any, other than as above and/or in the event of delay in excess of the above time limits arising from circumstances beyond the control of the Assured.

NOTE: It is necessary for the Assured to give prompt notice to Underwriters when he becomes aware of an event for which he is "held covered" under this policy and the right to such cover is dependent on compliance with this obligation.

APPENDIX XV

FREE OF PARTICULAR AVERAGE ENGLISH CONDITIONS (F.P.A.E.C.) CLAUSE

Warranted free from Particular Average unless the vessel or craft be stranded, sunk, or burnt, but notwithstanding this warranty the Underwriters are to pay the insured value of any package or packages which may be totally lost in loading, transshipment or discharge, also for any loss of or damage to the interest insured which may reasonably be attributed to fire, explosion, collision or contact of the vessel and/or craft and/or conveyance with any external substance (ice included) other than water, or to discharge of cargo at port of distress, also to pay landing, warehousing, forwarding and special charges if incurred for which Underwriters would be liable under a policy covering Particular Average. This clause shall operate during the whole period covered by the policy.

APPENDIX XVI

FREE OF PARTICULAR AVERAGE AMERICAN CONDITIONS (F.P.A.A.C.) CLAUSE

Free of Particular Average unless caused by stranding, sinking, burning or collision, with another vessel.

APPENDIX XVII

MARINE EXTENSION CLAUSES

American Institute

(April, 1943)

Notwithstanding anything to the contrary contained herein or endorsed hereon it is understood and agreed that in consideration of an additional premium this insurance is subject to the following terms and conditions:

1. This insurance attaches from the time the goods leave the warehouse at the place named in this policy or certificate for the commencement of the transit and continues until the goods are delivered to the final warehouse at the destination named in this policy or certificate, or a substituted destination as provided in Clause 3 hereunder.

2. This insurance specially to cover the goods during,

   (i) deviation, delay, forced discharge, re-shipment and transhipment.
   (ii) any other variation of the adventure arising from the exercise of a liberty granted to the shipowner or charterer under the contract of affreightment.

3. In the event of the exercise of any liberty granted to the shipowner or charterer under the contract of affreightment whereby such contract is terminated at a port or place other than the destination named herein, the insurance continues until the goods are sold and delivered at such port or place; or, if the goods be not sold but are forwarded to the destination named herein or to any other destination this insurance continues until the goods have arrived at final warehouse as provided in Clause 1.

4. If while this insurance is still in force and before the expiry of 15 days from midnight of the day on which the discharge overside of the goods hereby insured from the overseas vessel at the final port of discharge is completed, the goods are re-sold (not being a sale within the terms of Clause 3) and are to be forwarded to a destination other than that covered by this insurance, the goods are covered hereunder while deposited at such port of discharge until again in transit or until the expiry of the aforementioned 15 days whichever shall first occur. If a sale is effected after the expiry of the aforementioned 15 days while this insurance is still in force the protection afforded hereunder shall cease as from the time of the sale.

5. Held covered at a premium to be arranged in case of change of voyage or of any omission or error in the description of the interest vessel or voyage.

6. This insurance shall in no case be deemed to extend to cover loss damage or expense proximately caused by delay or inherent vice or nature of the subject-matter insured.

7. It is a condition of this insurance that there shall be no interruption or suspension of transit unless due to circumstances beyond the control of the Assured.

All other terms and conditions not in conflict with the foregoing remain unchanged, it being particularly understood and agreed that nothing in the foregoing shall be construed as overruling the F. C. & S. provisions of Clause No. 12 (first paragraph) or as extending this insurance to cover any risks of war or consequences of hostilities.

The Marine Extension clauses do not apply to the following shipments:

(a) Between parts in the Continental United States (excluding Alaska);
(b) Continental United States (excluding Alaska) to/from Canada;
(c) Canada to Canada;
(d) Newfoundland to Newfoundland;
(e) Shipments by air conveyances.

APPENDIX XVIII

EARTHQUAKE ENDORSEMENT

STANDARD FORMS BUREAU FORM 194 (MAR. 1934)

EARTHQUAKE POLICY FORM.

(INCLUDING DEDUCTIBLE AND AVERAGE CLAUSE)

[Space for description of risk.]

No insurance attaches under any of the items hereinabove set forth unless a certain amount is specified and inserted in the blank immediately preceding the item.

This policy (subject to all the provisions set forth in this rider and subject in all other respects to all the terms, conditions and provisions of this policy, including the stipulations and endorsements attached thereto) covers loss or damage to the above described subject of insurance caused directly by earthquake only. For the purpose of this entire policy the word "earthquake" is hereby substituted for the word "fire" wherever appearing in this policy and its stipulations and endorsements other than in this rider.

1. "EARTHQUAKE—DEFINED AND LIMITED." Each loss by earthquake shall constitute a single claim hereunder; provided, if more than one earthquake shock shall occur within any period of seventy-two hours during the term of this policy, such earthquake shocks shall be deemed to be a single earthquake within the meaning hereof. This Company shall not be liable for any loss or damage caused by any earthquake shock occurring before the effective date and time of this policy, nor for any loss or damage occurring after the expiration date and time of this policy.

2. "PLATE GLASS CLAUSE." This Company shall not be liable hereunder for loss or damage by earthquake to glass, or lettering or ornamentation thereon, which at the time of such loss or damage may be separately insured as such against loss or damage by earthquake under any other policy of insurance.

3. "PERILS NOT INSURED AGAINST." In no event shall this Company be liable for any loss or damage caused directly or indirectly by fire, explosion, or flood of any nature, or by tidal wave, whether the same be caused by or be attributable to earthquake, or otherwise.

4. "DEDUCTIBLE AND AVERAGE CLAUSE." This policy does not cover or become insurance against any portion of loss or damage by earthquake which shall be less than.................................per cent of the actual cash value of the above
Not less than 5%
described subject of insurance at the time of such loss or damage; nor shall this Company be liable for a greater proportion of the loss or damage in excess of such percentage than the amount hereby insured bears to..............................per cent of .... per cent of the actual cash value of the above described subject of insurance at the time such
Difference between per cent deductible and 100%
loss shall occur, nor for a greater proportion of such excess than the amount of this policy shall bear to all earthquake insurance (other than that portion of any earthquake insurance written to cover the amount deducted through operation of the Deductible Clause herein) whether valid or invalid or by solvent or insolvent insurers.

5. Permission is hereby granted to make alterations or repairs to the above described property without limit of time; to do such work in or about said property as the nature of the occupancy may require; to work or operate at any and all times, or cease to operate without limit of time; to generate illuminating gas or vapor in or adjacent to any building hereinabove described, and to keep, use and allow therein any and all articles, things and materials without any limit whatsoever as to quantities; and for such building to remain vacant or unoccupied without limit of time.

The liability of this Company hereunder shall in no way be affected by invasion, insurrection, riot, civil war or commotion, or by military or usurped power, or by any order of civil authority or by any act or neglect of the insured when the within described property is endangered by earthquake or by explosion or by lightning.

In event of loss this Company will not require any statement from said insured as to his belief as to the origin of such earthquake, nor in such event will this Company assert any right of subrogation by reason of the cause of such loss.

6. If this policy is divided into two or more items, or shall cover under any item two or more buildings or structures and/or contents thereof, the provisions of this rider shall be applied separately to each such item, building, structure and/or contents thereof.

7. Other earthquake insurance permitted.

8. Loss, if any, subject however to all the terms and conditions of this policy, payable to

....

Attached to Policy No.......................................of the..
Name of Company

Agency at..., Dated...

TRADE MARK STANDARD REG. U.S. PAT. OFF.
194
MAR. 1934

INSURANCE MAP	SPECIAL RATE	
Sheet....................	Page....................	
Block....................		
No....................	Line....................	.... Agent.

APPENDIX XIX

LIFE-INSURANCE POLICY

LIFE INSURANCE COMPANY

A MUTUAL COMPANY

AGREES TO PAY

to MARY, WIFE OF THE INSURED

* * * BENEFICIARY,

subject to the terms and conditions of this Policy,

TEN THOUSAND DOLLARS

(*The Face Amount of this Policy*)

upon receipt of due proof of the death of

JOHN DOE the INSURED,

or TWENTY THOUSAND DOLLARS

(*Double the Face Amount of this Policy*)

if such death resulted, before the anniversary of this Policy on which the Insured's age at nearest birthday is 65, from accidental means as limited in and subject to the provisions set forth herein under DOUBLE INDEMNITY BENEFIT.

This Policy also provides a TOTAL AND PERMANENT DISABILITY WAIVER OF PREMIUM BENEFIT subject to the terms and conditions set forth herein.

This contract is made in consideration of the application therefor and of the payment in advance of the sum of \$ 322.80 (including \$ 13.20 and \$ 14.80 for the Double Indemnity Benefit and the Waiver of Premium Benefit, respectively), the receipt of which is hereby acknowledged, constituting the first premium and maintaining this Policy for the period terminating on June 1st 19 45 , and of a like sum on said date and every Twelve calendar months thereafter during the lifetime of the Insured prior to the anniversary of this Policy on which the Insured's age at nearest birthday is 85, except as any such premium may be waived or reduced under the provisions of this Policy.

The anniversaries and insurance years of this policy shall be determined from June 1st 19 44 , the date as of which this Policy shall be deemed to have taken effect.

The BENEFITS, PROVISIONS AND CONDITIONS printed or written by the Company on the following pages are a part of this Policy.

In Witness Whereof the LIFE INSURANCE COMPANY has caused this Policy to be executed on June 1st 19 44 , which is its date of issue

Secretary SPECIMEN COPY *President*

Countersignature

944–51

L. Pd-up at 85
D.-D. I.

Life Paid-up at Age 85. Insurance Payable at Death. Premiums Payable to Age 85 unless Dividends Applied to Shorten Premium Paying Period. Double Indemnity Benefit. Total and Permanent Disability Waiver of Premium Benefit. Annual Participation in Divisible Surplus. All Subject to the Terms and Conditions of this Policy.

Age 35

DOUBLE INDEMNITY BENEFIT

The Double Indemnity Benefit specified on the first page hereof shall be payable upon receipt of due proof that the death of the Insured resulted directly, and independently of all other causes, from bodily injury effected solely through external, violent and accidental means and occurred

(1) within ninety days after such injury, and
(2) before default in payment of premium (or, in event of default, not later than the last day of grace), and
(3) before the anniversary of this Policy on which the Insured's age at nearest birthday is 65, and prior to the maturity of this Policy;

provided, however, that such Double Indemnity Benefit shall not be payable if the Insured's death resulted from any one or more of the following:—self-destruction, whether sane or insane; the taking of poison or inhaling of gas, whether voluntary or otherwise; committing an assault or felony; war or any act incident thereto; engaging in riot or insurrection; operating or riding in any kind of aircraft (including falling or otherwise descending from or with any such aircraft in flight) other than as a fare-paying passenger of a commercial airline and flying on a regularly scheduled route; infirmity of mind or body; illness or disease; any bacterial infection other than that occurring in consequence of an injury on the exterior of the body effected solely through external, violent and accidental means.

The Company shall have the right and opportunity to examine the body and to make an autopsy unless prohibited by law.

The Double Indemnity Benefit shall not be payable if death occurs while this Policy is continued as Non-Participating Extended Term Insurance or Participating Paid-up Insurance as provided under Non-Forfeiture Provisions and shall not apply to any dividend additions provided under Participation in Divisible Surplus.

Any premium due on or after the anniversary of this Policy on which the Insured's age at nearest birthday is 65 will be reduced by the amount included therein for the Double Indemnity Benefit. If, however, said reduction shall not have been made and said amount shall have been paid to and received by the Company as a part of any such premium, the amount overpaid with interest thereon at five per cent per annum will be refunded and the Company shall not incur any other or further obligation or liability under these provisions for Double Indemnity Benefit.

Upon receipt by the Company, on any anniversary of this Policy or within thirty-one days thereafter, of written request by the Insured and the return of this Policy for proper indorsement, the Company will terminate these provisions for Double Indemnity Benefit as of such anniversary and thereafter the premium will be reduced by the amount included therein for such benefit.

TOTAL AND PERMANENT DISABILITY WAIVER OF PREMIUM BENEFIT

Upon receipt by the Company at its Home Office of due proof, as hereinafter provided, that the Insured has become totally disabled by bodily

injury or disease so that the Insured is and will be thereby wholly prevented from performing any work, following any occupation, or engaging in any business for remuneration or profit, and that such disability has already continued uninterruptedly for a period of at least six months (such total disability of such duration being presumed to be permanent only for the purpose of determining liability hereunder), and provided that

(1) such total disability began before default in payment of premium (or, in event of default, not later than the last day of grace), and that
(2) such total disability began before the anniversary of this Policy on which the Insured's age at nearest birthday is 60, and prior to the maturity of this Policy, and that
(3) such total disability did not arise from bodily injury or disease occurring before the insurance under this Policy took effect, and known to the Insured, but not disclosed in the application for the insurance under this Policy, and that
(4) such total disability did not result from any one or more of the following:—wilfully and intentionally self-inflicted injury; service in the military, naval or air forces of any country engaged in war; operating or riding in any kind of aircraft (including falling or otherwise descending from or with any such aircraft in flight) other than as a fare-paying passenger of a commercial airline and flying on a regularly scheduled route; and that
(5) such total disability has been continuous from the beginning of the period of disability claimed,

the Company will waive the payment of each premium falling due after the commencement of such total disability and during its continuance, provided, however, that no premium shall be waived which shall have fallen due more than one year prior to the date of receipt by the Company of written notice of claim, as hereinafter provided. The premium to be waived shall be the premium according to the mode of payment in effect when such total disability began. If such total disability began during the grace period and the Insured is in default but not more than one year in default, this Policy will be restored if the Insured pays to the Company the overdue premiums with interest thereon at five per cent per annum when the claim is approved. Any premium falling due after notice of claim is received and prior to approval of claim shall be payable in accordance with the terms of this Policy, but will, if paid to and received by the Company, be refunded upon approval of such claim.

Independently of any other cause of disability, the total and irrecoverable loss of the sight of both eyes, or of the use of both hands or of both feet or of one hand and one foot, shall be considered total disability.

Written notice of claim hereunder must be received by the Company at its Home Office during the lifetime and during the continuance of total disability of the Insured. Failure to give such notice within such times shall not invalidate or diminish any such claim if it shall be shown not to have been reasonably possible to give such notice within such times and that notice was given as soon as was reasonably possible.

Due proof of claim must be received by the Company at its Home Office before the expiration of one year after default in payment of premium and in any event, whether or not there be a default, not later than one year from the anniversary of this Policy on which the Insured's age at nearest birthday is 60 or one year after maturity of this Policy, whichever is the earlier date, otherwise the claim shall be invalid.

Before waiving any premium, the Company may demand due proof of the continuance of total disability, but such proof will not be required oftener than once a year after such disability has continued for two full years. If such proof shall not be furnished, or if at any time the Insured shall become able to perform any work, follow any occupation, or engage in any business for remuneration or profit, no further premiums shall be waived. If, however, any such premiums shall have been waived they shall constitute an indebtedness against this Policy bearing interest as provided for loans under Loan Provisions.

The sum payable in any settlement of this Policy shall not be reduced by premiums waived hereunder. Dividends, loan and non-forfeiture values shall be the same as if the waived premiums had been duly paid. Any premium paid to and received by the Company and later waived under the provisions hereof but not refunded by the Company prior to the Insured's death shall be payable to the person or persons entitled to the proceeds of this Policy.

Any premium due on or after the anniversary of this Policy on which the Insured's age at nearest birthday is 60 will be reduced by the amount included therein for the Total and Permanent Disability Waiver of Premium Benefit (herein referred to as Waiver of Premium Benefit). If, however, said reduction shall not have been made and said amount shall have been paid to and received by the Company as a part of any such premium, the amount overpaid with interest thereon at five per cent per annum will be refunded and the Company shall not incur any other or further obligation or liability under these provisions for Waiver of Premium Benefit.

If this Policy shall be made a fully paid participating policy by the application of dividends as provided herein, these provisions for Waiver of Premium Benefit shall thereupon terminate.

Upon receipt by the Company, on any anniversary of this Policy or within thirty-one days thereafter, of written request by the Insured and the return of this Policy for proper indorsement, the Company will terminate these provisions for Waiver of Premium Benefits as of such anniversary and thereafter the premium will be reduced by the amount included therein for such benefit.

PARTICIPATION IN DIVISIBLE SURPLUS

The proportion of divisible surplus accruing upon this Policy shall be ascertained annually by the Company. On the anniversary of this Policy following the date as of which such ascertainment was made, and provided all premiums due hereunder have been paid to such anniversary, such surplus

as shall have been apportioned by the Company to this Policy shall become a dividend due and payable and, at the option of the Insured, shall be either

(*a*) paid in cash; or
(*b*) applied toward payment of the premium, if any, then due hereunder provided the balance of said premium is paid before the expiration of the grace period; or
(*c*) applied to provide a participating paid-up addition to the sum insured (such additions being herein referred to as dividend additions); or
(*d*) left with the company to accumulate at interest (herein referred to as a dividend accumulation). On each succeeding anniversary of this Policy, interest at such rate as the Company may declare for the insurance year then ending will be credited on dividend accumulations previously left with the Company and outstanding on such anniversary. Outstanding dividend accumulations may be withdrawn in cash by the Insured or shall be payable at the maturity of this Policy to the person or persons entitled to its proceeds.

If no option is selected, the dividend will be applied to provide a dividend addition. The Insured may surrender any dividend addition for cash at any time not later than three months after any default in payment of premium, and the cash value thereof shall never be less than the original cash dividend.

It is not contemplated that there will be any dividend credited to this Policy before its second anniversary.

Dividends May Be Applied to Decrease Number of Premium Payments or to Mature Policy as an Endowment

Whenever the Cash Value of this Policy (including the reserve on any outstanding dividend additions and any outstanding dividends, including dividend accumulations) shall equal the net single premium, calculated on the same basis as the premium on this Policy, at the attained age of the Insured at nearest birthday for a fully paid participating policy of the same kind and face amount as this Policy, the Company, upon receipt, before default in payment of premium or within the grace period, of written request by the Insured and upon surrender of said dividend additions and outstanding dividends, including dividend accumulations, will indorse this Policy as fully paid, whereupon no further payment of premium will be required; or whenever said Cash Value shall equal the face amount of this Policy, the Company, upon request as above and due surrender of this Policy, will pay the face amount hereof in cash less any indebtedness to the Company.

MISCELLANEOUS BENEFITS

1. Privilege of Automatic Premium Loans

Upon receipt by the Company, before default in payment of premium or within the grace period, of a written request by the Insured, duly acknowl-

edged by the Company, this Policy shall be subject to the following provision for Automatic Premium Loans:

After premiums shall have been paid under this Policy for the minimum number of full years specified under Non-Forfeiture Provisions, if any premium which becomes due hereunder is not paid before the expiration of the grace period, the amount of such premium shall be charged automatically as a loan against this Policy, provided such loan together with any other indebtedness to the Company on this Policy (including accrued interest) shall be within its loan value. Automatic Premium Loans shall be subject to the same terms and conditions as provided for other loans under Loan Provisions.

If the loan value shall be insufficient to permit the overdue premium being so charged, this provision for Automatic Premium Loans shall not apply but instead the provisions under Non-Forfeiture Provisions shall apply.

If this Policy shall have been made subject to this provision for Automatic Premium Loans as above, then upon subsequent receipt by the Company, before default in payment of premium or within the grace period, of a written request by the Insured, duly acknowledged by the Company, this provision for Automatic Premium Loans shall not apply to any premium then due nor to premiums subsequently falling due. The Insured, however, may again apply as above for this Privilege of Automatic Premium Loans.

2. Privilege of Change

At any time before default in payment of premium, provided the Insured is then less than 55 years of age and has not become totally disabled at any time as defined in any provisions for Waiver of Premium Benefit contained herein, the Insured, without medical examination, may exchange this Policy for a new policy of the same face amount and amount of initial risk as this Policy on any Limited Payment Life or Endowment plan of insurance issued by the Company with a higher rate of premium at the time this Policy took effect, provided all premiums for the new policy would not have fallen due before the date of exchange. The exchange shall be effective upon surrender of this Policy and the payment to the Company of the difference in premiums, with compound interest at six per cent per annum from the due date of each premium to the date of exchange, with proper adjustment for the difference between the dividends under the two plans of insurance.

With the approval of the Company and the furnishing of such requirements as the Company may consider necessary, the Insured may exchange this Policy for a new policy on any plan of insurance which was issued by the Company at the time this Policy took effect or for a policy of lesser amount.

Any new policy shall be without provisions for Double Indemnity Benefit or Waiver of Premium Benefit unless this Policy shall contain such provisions at the time of the exchange, in which event the new policy may, at the

option of the Insured, contain the same provisions for Double Indemnity Benefit or Waiver of Premium Benefit, as the case may be, as are contained in similar policies issued by the Company at the time this Policy took effect. The new policy will take effect as of the effective date of this Policy and the premium will be at the rate which would have been charged if this Policy had been issued originally on the new basis.

3. Grace Period for Payment of Premium

If any premium is not paid on or before the day it falls due the policyholder is in default; but a grace of thirty-one days will be allowed for the payment of every premium after the first, during which time the insurance continues in force. If deaths occurs within the grace period the overdue premium will be deducted in any settlement hereunder.

4. Assignment

Any assignment of this Policy must be made in duplicate and one copy filed with the Company at its Home Office. The Company assumes no responsibility for the validity of any assignment. Without prejudice to the Company on account of any payment made by it before copy of the assignment had been filed with the Company, any assignment of this Policy shall operate, so long as such assignment remains in force and to the extent thereof, to transfer the interest of the then existing beneficiary except that the interest of any irrevocably designated beneficiary can be transferred only with the written consent of such beneficiary.

5. Change of Beneficiary

The Insured may, from time to time, change the beneficiary unless otherwise provided herein or by indorsement hereon. The interest of the new beneficiary shall be subject to the rights of any then existing assignee. An assignee cannot change the beneficiary. Every change of beneficiary must be made by written notice to the Company at its Home Office accompanied by this Policy for indorsement of the change hereon by the Company, and unless so indorsed the change shall not take effect. After such indorsement the change will relate back to and take effect as of the date said written notice of change was signed, whether the Insured be living at the time of such indorsement or not, but without prejudice to the Company on account of any payment made by it before receipt of such written notice at its Home Office.

6. Death of Beneficiary

Unless otherwise provided herein or by indorsement hereon (*a*) if any revocably or irrevocably designated beneficiary shall die before the Insured the interest of such beneficiary shall vest in the Insured, or (*b*) if any such beneficiary shall die simultaneously with the Insured, or within fifteen days after the Insured but before due proof of the Insured's death shall have been received at the Home Office of the Company, payment of the proceeds of

this Policy shall be made to the same payee or payees, and under the same terms and conditions, as provided for in this Policy in the event that said deceased beneficiary was not living at the death of the Insured.

7. Rights of Insured

During the lifetime of the Insured and without the consent of the beneficiary, whether revocably or irrevocably designated, the Insured may receive every benefit, exercise every right and enjoy every privilege conferred upon the Insured by this Policy, unless otherwise provided herein or by indorsement hereon, and except that any irrevocably designated beneficiary can be changed only with the written consent of such beneficiary.

OPTIONAL METHODS OF SETTLEMENT

The Insured, or in case the Insured shall not have done so, the beneficiary after the Insured's death, may, by written notice to the Company, elect to have the proceeds of this Policy in whole or in part made payable under one of the following options, except that Option 4 may not be elected by the beneficiary. Unless otherwise provided herein or by indorsement hereon, the Insured may, by written notice to the Company, revoke or change any such election at any time before the maturity of this Policy. Any such election, revocation or change shall not take effect until indorsed on this Policy by the Company. The Optional Methods of Settlement shall be applicable whether such proceeds are payable as a death claim or on maturity as an endowment or upon surrender of this Policy for its cash value, provided in any event that the instalment or interest payment to any payee is not less than $10. The Optional Methods of Settlement shall not be available, and if previously elected shall not apply, if the payee is not a natural person taking in his or her own right, nor without the consent of the Company if this Policy is assigned.

Proceeds Left With Company

Option 1.—The proceeds in whole or in part may be left with the Company subject to withdrawal in sums of not less than one hundred dollars. Interest will be credited annually in such amount as the Company shall determine hereunder in accordance with such rate of interest as the Company may declare each year under this option.

Instalment Payments for a Fixed Period

Option 2.—The proceeds in whole or in part may be made payable in equal annual, semi-annual, quarterly or monthly instalments for a fixed period as may be agreed upon, in accordance with the following table (which is based on a guaranteed interest rate of two per cent per annum). The first instalment will be payable as of the date when the proceeds of this Policy become due. The instalment payable on each anniversary of the first instalment due date will be increased by such amount of additional interest as the Company shall determine to be payable hereunder in accord-

TABLE OF MONTHLY INSTALMENTS PER $1,000 OF PROCEEDS OF POLICY MADE PAYABLE UNDER OPTION 2 or 3

OPTION 2		OPTION 3											
Number of Years' Payments	Monthly Instalment	Age of Payee, Nearest Birthday, When Proceeds Become Due		Monthly Instalment Payable for Life with Fixed Period of		Age of Payee, Nearest Birthday, When Proceeds Become Due		Monthly Instalment Payable for Life with Fixed Period of		Age of Payee, Nearest Birthday, When Proceeds Become Due		Monthly Instalment Payable for Life with Fixed Period of	
		Male	Female	10 Years	20 Years	Male	Female	10 Years	20 Years	Male	Female	10 Years	20 Years
1	$84.09	..	10 and under	$2.32	$2.31	36	41	$3.25	$3.18	67	72	$6.35	$4.82
2	42.46	..	11	2.33	2.32	37	42	3.30	3.22	68	73	6.50	4.85
3	28.59	..	12	2.35	2.34	38	43	3.36	3.27	69	74	6.66	4.88
4	21.65	..	13	2.37	2.36	39	44	3.41	3.32	70	75	6.82	4.91
5	17.49	..	14	2.38	2.37	40	45	3.47	3.37	71	76	6.98	4.93
6	14.72	10 and under	15	2.40	2.39	41	46	3.54	3.42	72	77	7.14	4.95
7	12.74	11	16	2.42	2.41	42	47	3.60	3.47	73	78	7.29	4.97
8	11.25	12	17	2.44	2.43	43	48	3.67	3.52	74	79	7.45	4.98
9	10.10	13	18	2.46	2.45	44	49	3.74	3.58	75	80	7.60	5.00
10	9.18	14	19	2.48	2.47	45	50	3.81	3.63	76	81	7.75	5.01
11	8.42	15	20	2.51	2.49	46	51	3.89	3.69	77	82	7.89	5.02
12	7.80	16	21	2.53	2.52	47	52	3.97	3.74	78	83	8.03	5.02
13	7.26	17	22	2.55	2.54	48	53	4.05	3.80	79	84	8.16	5.03
14	6.81	18	23	2.58	2.56	49	54	4.14	3.86	80	85 and over	8.28	5.03
15	6.42	19	24	2.60	2.59	50	55	4.23	3.92	81		8.40	5.03
16	6.07	20	25	2.63	2.62	51	56	4.32	3.98	82		8.51	5.03
17	5.77	21	26	2.66	2.64	52	57	4.42	4.04	83		8.60	5.03
18	5.50	22	27	2.69	2.67	53	58	4.52	4.10	84		8.69	5.03
19	5.26	23	28	2.72	2.70	54	59	4.62	4.16	85 and over		8.78	5.03
20	5.04	24	29	2.75	2.73	55	60	4.73	4.22				
21	4.85	25	30	2.78	2.76	56	61	4.85	4.28				
22	4.67	26	31	2.82	2.79	57	62	4.96	4.34				
23	4.51	27	32	2.85	2.83	58	63	5.08	4.39				
24	4.36	28	33	2.89	2.86	59	64	5.21	4.45				
25	4.22	29	34	2.93	2.90	60	65	5.34	4.50				
26	4.10	30	35	2.97	2.93	61	66	5.47	4.56				
27	3.98	31	36	3.01	2.97	62	67	5.61	4.61				
28	3.87	32	37	3.06	3.01	63	68	5.75	4.65				
29	3.77	33	38	3.10	3.05	64	69	5.89	4.70				
30	3.68	34	39	3.15	3.09	65	70	6.04	4.74				
		35	40	3.20	3.13	66	71	6.19	4.78				

To Determine Quarterly, Semi-Annual and Annual Instalments Under Option 2 or 3

Multiply the Monthly Instalment by	OPTION 2	OPTION 3
Quarterly	2.99	2.99
Semi-Annual	5.97	5.95
Annual	11.88	11.80

ance with such rate of additional interest as the Company may declare each year under this option.

Life Income with Payments Guaranteed for a Fixed Period

Option 3.—The proceeds in whole or in part may be made payable in equal annual, semi-annual, quarterly or monthly instalments for a fixed period of ten or twenty years, as may be agreed upon, and for the remaining lifetime of the payee, in accordance with the following table (which is based on a guaranteed interest rate of two per cent per annum). The first instalment will be payable as of the date when the proceeds of this Policy become due. The instalment payable on each anniversary of the first instalment due date will be increased by such amount of additional interest as the Company shall determine to be payable hereunder in accordance with such rate of additional interest as the Company may declare each year under this option.

Proceeds Left with Company Until Death of Payee

Option 4.—The proceeds in whole or in part may be left with the Company until the death of the payee. Interest will be paid annually, semi-annually, quarterly or monthly, as may be agreed upon, in such amount as the Company shall determine to be payable hereunder in accordance with such rate of interest as the Company may declare each year under this option. The Company guarantees that such interest, per one thousand dollars of proceeds left, shall be not less than $20 when paid annually, $9.95 when paid semi-annually, $4.96 when paid quarterly, or $1.65 when paid monthly. The first interest payment shall be made one year after the date when the proceeds of this Policy become due, if the interest is payable annually; six months after, if the interest is payable semi-annually; three months after, if quarterly; or one month after, if monthly.

Instalment Payments of a Fixed Amount

Option 5.—The proceeds in whole or in part may be made payable in equal annual, semi-annual, quarterly or monthly instalments of such amount as may be agreed upon provided that the fixed amount payable each year shall be not less than five per cent of the original proceeds made payable under this option. Such instalments shall be payable until the entire proceeds left with the Company have been paid, including interest credited annually in such amount as the Company shall determine hereunder in accordance with such rate (guaranteed to be not less than two per cent per annum) as the Company may declare each year under this option. The first instalment will be payable as of the date when the proceeds of this Policy become due.

Miscellaneous Provisions Relating to Optional Methods of Settlement

At the death of any payee any unpaid sum left with the Company under Option 1 or 4 with any accrued interest to date of such death, or the com-

muted value as of the date of death on the basis of interest at two per cent compounded annually of any unpaid instalments under Option 2 or 5 or of any unpaid instalments for the fixed period selected under Option 3, will be paid in one sum to the executors or administrators of the payee, unless otherwise agreed in writing.

When the proceeds of this Policy become payable the Company will deliver to each payee a certificate evidencing the rights and benefits of such payee under the option elected. The Company reserves the right to require satisfactory evidence of age of the payee before making any payment under Option 3.

If one of the above options shall have been elected by a person other than the payee and said person has not otherwise directed in writing, the benefits under such option shall not be transferable nor subject to incumbrance during the lifetime of the payee.

Special Agreements

Provision may be made for payment of the proceeds of this Policy in any other manner that may be agreed to by the Company.

LOAN AND NON-FORFEITURE PROVISIONS

1. LOAN PROVISIONS

After three full years' premiums have been paid and before default in payment of premium or within the grace period, the Company, upon receipt of this Policy and a Loan Agreement satisfactory to the Company, will advance to the Insured on the sole security of this Policy any amount which, with interest, shall be within the limit of the Cash Value of this Policy. Any existing indebtedness to the Company on this Policy (including accrued interest) will be deducted from the amount of the loan. Interest on the loan shall be at the rate of five per cent per annum and will be payable each year on the anniversary of this Policy except as otherwise provided hereunder. All interest shall accrue from day to day and shall constitute an indebtedness to the Company against this Policy as and when it accrues. If interest is not paid when due it shall be added to and form a part of the principal, and bear interest at the same rate. All or any part of the principal may be repaid, with accrued interest on the amount so repaid, at any time before default in payment of premium or within the grace period, provided this Policy shall not have matured as an endowment or by the death of the Insured. Whenever the total indebtedness is no longer within the limit of the then loan value, this Policy shall be void thirty-one days after the Company shall have mailed notice to the last known address of the Insured and of the assignee of record, if any.

2. PRIVILEGE OF TERM INSURANCE IN CASE OF LOAN

Prior to the anniversary of this Policy on which the Insured's age at nearest birthday is 65, term insurance as follows for the amount of any loan

under this Policy may be obtained by the Insured upon written application therefor on the following conditions:

(a) Evidence of insurability satisfactory to the Company must be received.

(b) Such term insurance shall be for the period to the next anniversary of this Policy. The premium therefor shall be payable in advance and shall be computed, in accordance with the following table, at the attained age of the Insured at nearest birthday:

Premiums for each $100 of Term Insurance

Attained Age, Nearest Birthday	Premiums for One Year	Attained Age, Nearest Birthday	Premiums for One Year	Attained Age, Nearest Birthday	Premiums for One Year
25 and under	$0.90	51	$1.40	58	$2.25
26–45	1.00	52	1.50	59	2.40
46	1.10	53	1.60	60	2.60
47	1.20	54	1.70	61	2.80
48	1.25	55	1.80	62	3.05
49	1.30	56	1.95	63	3.30
50	1.35	57	2.10	64	3.60

For periods of less than one year, the premium shall be at the rate of one-tenth of the one year rate for each month or fraction of a month, but in no event shall exceed the premium for one year.

(c) If the indebtedness on account of a loan shall be reduced or repaid or shall be satisfied in accordance with the terms of the Loan Agreement, the term insurance shall thereupon automatically be reduced or canceled accordingly and any unearned premium paid therefor will be refunded.

(d) Such term insurance takes effect upon delivery to the Insured of the Company's policy therefor and when payable shall be applied to the reduction of the indebtedness.

(e) In event of self-destruction, whether the Insured be sane or insane, the term insurance shall be null and void and the premium paid therefor shall be applied to the reduction of the indebtedness.

Such term insurance may be obtained again on the same conditions from year to year. However, such term insurance may not be obtained to extend beyond the anniversary of this Policy on which the Insured's age at nearest birthday is 65.

3. NON-FORFEITURE PROVISIONS

In event of default in payment of premium after three full years' premiums have been paid, the following benefits shall apply if the premium remains unpaid and the Automatic Premium Loan provision is not applicable:

(a) **Non-Participating Extended Term Insurance**:—Insurance for the face amount of this Policy plus any outstanding dividend additions and any outstanding dividends, including dividend accumulations, and less the amount of any indebtedness hereon, shall, upon expiration of the grace period, be continued automatically as Non-Participating Extended Term Insurance as from the date of default for such term as the then Cash Value less any indebtedness hereon will provide, at the Insured's attained age nearest birthday at such date, according to the American Experience Table of Mortality and interest at two and one-half per cent per annum. The Insured's election of Participating Paid-up Insurance or Cash Value, as hereinafter provided, will revoke the automatic application of the Cash Value less any indebtedness to provide Non-Participating Extended Term Insurance hereunder; no deduction will be made for the value of any such Extended Term Insurance for the period elapsed before such election is made.

(b) **Participating Paid-up Insurance**:—Within three months after such default, but not later, the Insured may elect in place of such Non-Participating Extended Term Insurance to have this Policy indorsed by the Company for the amount of Participating Paid-up Insurance which the Cash Value at date of default less any indebtedness hereon will provide, at the Insured's attained age nearest birthday at such date, according to the American Experience Table of Mortality and interest at two and one-half per cent per annum. The Insured may obtain a loan on such Paid-up Insurance subject to the loan provisions hereof, or may surrender such Insurance within one month after any anniversary of this Policy for its Cash Value as at such anniversary less any indebtedness.

(c) **Cash Value**:—Within three months after such default, but not later, the Insured may elect in place of such Non-Participating Extended Term Insurance or Participating Paid-up Insurance to surrender this Policy and all claims hereunder and receive its Cash Value as at date of default less any indebtedness hereon. The Cash Value at date of default shall be the amount determined in accordance with the following table, together with the reserve according to the American Experience Table of Mortality and interest at two and one-half per cent per annum on any outstanding dividend additions, and any outstanding dividends, including dividend accumulations.

4. CASH VALUE OF FULLY PAID POLICY

If this Policy shall have become fully paid by its terms, the Insured at any time may surrender this Policy and all claims hereunder and receive its then Cash Value less any indebtedness hereon. Such Cash Value shall be computed in accordance with the Basis of Computation described in the following table.

TABLE OF LOAN AND NON-FORFEITURE VALUES

The values in this Table are computed on the assumption that the Policy has been in force and premiums duly paid for the number of years stated, that there is no indebtedness to the Company, and that there are no outstanding dividend additions, nor outstanding dividends or dividend accumulations. If the Face Amount of the Policy is other than $1,000, the values shown in this Table for Cash Value or Loan Value and for Participating Paid-up Insurance will apply pro-rata.

Basis of Computation:—The Cash Values or Loan Values shown in this Table are for $1,000 Face Amount. Prior to the end of the tenth insurance year such values are the reserve on $1,000 of Face Amount according to the American Experience Table of Mortality and interest at two and one-half per cent per annum by the net level premium method less an amount which from the end of the third insurance year is never greater than twenty-five dollars per $1,000 of Face Amount. At the end of the tenth insurance year and thereafter such values are the full amount of said reserve, taken to the next higher dollar if it involves a fraction of a dollar. Such values are applicable whether or not the Policy contains any provisions for Double Indemnity Benefit or Waiver of Premium Benefit.

THE VALUES APLYING TO THIS POLICY ARE THOSE IN COLUMN HEADED WITH AGE 35* .													
End of Year	AGE 28	AGE 29	AGE 30	AGE 31	AGE 32	AGE 33	AGE 34	AGE 35*	AGE 36	AGE 37	AGE 38	AGE 39	AGE 40
Cash Value or Loan Value for $1,000 of Face Amount of Policy													
3	$22	$23	$24	$25	$26	$27	$28	$29	$30	$31	$32	$34	$35
4	32	33	35	36	37	39	40	42	43	45	47	49	50
5	43	45	47	49	50	52	54	56	58	61	63	66	68
6	56	58	60	63	65	68	70	73	76	78	82	85	88
7	70	73	76	79	82	85	88	91	95	98	102	106	110
8	86	89	93	96	100	104	107	112	116	120	125	129	134
9	104	108	112	117	121	126	131	136	141	147	152	158	164
10	123	127	132	137	142	147	153	158	164	170	177	183	190
11	137	142	147	152	158	164	170	176	183	189	196	203	211
12	151	157	162	168	174	181	187	194	201	208	216	224	231
13	166	172	178	184	191	198	205	212	220	228	236	244	253
14	181	187	194	201	208	216	223	231	239	248	256	265	274
15	196	203	210	218	225	233	242	250	259	268	277	286	295

TABLE OF LOAN AND NON-FORFEITURE VALUES—(*Continued*)

End of Year	AGE 28	AGE 29	AGE 30	AGE 31	AGE 32	AGE 33	AGE 34	AGE 35*	AGE 36	AGE 37	AGE 38	AGE 39	AGE 40
16	212	219	227	235	243	252	260	269	278	288	297	307	317
17	228	236	244	252	261	270	279	289	298	308	318	328	339
18	244	252	261	270	279	289	298	308	318	328	339	349	360
19	260	269	279	288	298	307	318	328	338	349	360	371	382
20	277	287	296	306	316	327	337	348	359	370	381	392	403
21	294	304	314	325	335	346	357	368	379	390	402	413	425
22	312	322	332	343	354	365	376	388	399	411	423	435	447
23	329	340	351	362	373	384	396	408	419	431	444	456	468
24	347	358	369	381	392	404	416	428	440	452	464	477	489
25	365	376	388	400	411	423	435	448	460	472	485	498	520

Allowance will be made for any premium paid for a fractional part of a year beyond any number of full years shown.

Participating Paid-up Insurance for $1,000 of Face Amount of Policy

End of Year	AGE 28	AGE 29	AGE 30	AGE 31	AGE 32	AGE 33	AGE 34	AGE 35*	AGE 36	AGE 37	AGE 38	AGE 39	AGE 40
3	$49	$51	$52	$54	$55	$56	$57	$58	$59	$60	$61	$64	$65
4	70	72	75	76	77	80	80	83	84	86	89	91	91
5	93	96	99	101	102	104	107	109	111	115	117	120	122
6	119	122	124	128	130	134	136	139	143	144	149	152	155
7	147	151	155	158	162	165	168	171	176	178	183	187	191
8	178	181	186	189	194	198	201	207	211	215	220	223	228
9	211	216	221	227	231	237	242	247	252	259	263	269	275
10	246	250	256	261	267	271	278	282	288	294	301	306	313
11	270	275	280	285	292	298	304	310	317	322	328	334	342
12	293	299	304	310	316	324	329	336	342	348	356	363	368
13	316	323	329	334	341	348	355	361	368	376	382	389	397
14	340	345	352	359	366	374	379	387	394	402	408	416	423
15	362	369	375	383	389	396	405	412	420	427	435	442	448
16	385	391	399	406	413	422	428	436	443	452	459	467	474
17	407	415	422	429	437	445	452	461	468	476	483	491	500
18	429	436	444	452	459	468	475	483	491	499	507	514	523
19	450	458	467	474	483	489	499	506	514	522	531	539	546
20	471	480	487	496	504	513	520	529	537	545	553	561	568
21	492	501	509	518	526	534	543	551	559	566	575	582	590
22	514	522	529	538	547	555	563	572	579	588	596	604	612
23	533	542	551	559	567	575	584	592	599	607	617	625	632
24	553	562	570	579	587	595	604	612	620	628	635	644	652
25	573	581	590	599	606	614	622	631	639	646	655	664	671

TABLE OF LOAN AND NON-FORFEITURE VALUES—(*Continued*)

Non-Participating Extended Term Insurance for Face Amount of Policy, from date of default

This period is the same for policies of any Face Amount.

End of Year	AGE 28		AGE 29		AGE 30		AGE 31		AGE 32		AGE 33		AGE 33		AGE 35*		AGE 36		AGE 37		AGE 38		AGE 39		AGE 40	
	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days	Yrs.	Days
3	2	256	2	289	2	321	2	350	3	13	3	37	3	59	3	78	3	94	3	106	3	116	3	159	3	159
4	3	339	4	0	4	69	4	89	4	106	4	162	4	170	4	216	4	217	4	251	4	278	4	298	4	274
5	5	100	5	162	5	219	5	269	5	271	5	311	5	344	6	5	6	23	6	69	6	69	6	92	6	70
6	6	309	6	356	7	32	7	109	7	134	7	192	7	199	7	235	7	258	7	233	7	264	7	247	7	219
7	8	184	8	256	8	318	9	3	9	41	9	65	9	76	9	73	9	90	9	58	9	45	9	18	8	343
8	10	121	10	164	10	235	10	249	10	287	10	307	10	274	10	295	10	265	10	221	10	191	10	121	10	65
9	12	94	12	137	12	162	12	206	12	193	12	197	12	181	12	148	12	99	12	62	11	349	11	283	11	205
10	14	26	14	20	14	32	14	24	13	362	13	317	13	285	13	207	13	143	13	65	12	363	12	259	12	168
11	15	36	15	28	15	0	14	319	14	286	14	234	14	167	14	85	14	14	13	270	13	174	13	68	12	337
12	15	345	15	333	15	268	15	217	15	150	15	93	14	361	14	273	14	173	14	63	13	328	13	217	13	81
13	16	260	16	211	16	143	16	60	15	353	15	264	15	163	15	50	14	312	14	198	14	76	13	311	13	190
14	17	117	17	35	16	329	16	241	16	140	16	49	15	287	15	172	15	47	14	296	14	155	14	24	13	252
15	17	286	17	201	17	102	17	12	16	250	16	135	16	29	15	257	15	131	14	363	14	221	14	74	13	287
16	18	70	17	323	17	221	17	106	16	345	16	227	16	81	15	311	15	168	15	35	14	244	14	99	13	315
17	18	176	18	63	17	303	17	166	17	40	16	269	16	124	15	355	15	197	15	49	14	261	14	104	13	322
18	18	244	18	110	17	351	17	215	17	71	16	302	16	142	15	358	15	203	15	43	14	258	14	91	13	299
19	18	281	18	148	18	25	17	237	17	95	16	293	16	153	15	356	15	189	15	33	14	239	14	76	13	276
20	18	310	18	178	18	19	17	234	17	78	16	297	16	128	15	336	15	174	15	8	14	205	14	35	13	230
21	18	312	18	164	18	9	17	228	17	59	16	266	16	102	15	300	15	130	14	321	14	160	13	350	13	187
22	18	309	18	148	17	345	17	187	17	23	16	220	16	47	15	251	15	74	14	273	14	106	13	304	13	137
23	18	269	18	112	17	314	17	145	16	337	16	161	15	360	15	192	15	9	14	204	14	45	13	240	13	70
24	18	228	18	60	17	252	17	90	16	274	16	105	15	298	15	125	14	315	14	141	13	331	13	171	12	362
25	18	172	17	359	17	193	17	22	16	201	16	25	15	215	15	49	14	237	14	60	13	261	13	97	12	289

4451–5 (L. Pd-up at 85. 28–40) Values for later years will be computed on the same basis and will be furnished on request. The Loan obtainable at the end of any year may be secured during that year (less interest) if the premium for the entire year has been paid.

OTHER PROVISIONS

1. Age

If the age of the Insured has been misstated, any amount payable hereunder shall be such as the premium paid would have purchased at the correct age.

2. Premiums—Where and How Payable

All premiums after the first are payable on or before their due date at the Home Office of the Company or to a duly authorized Cashier of the Company, but only in exchange for the Company's official premium receipt signed by the President, the Executive Vice-President, a Vice-President, the Treasurer or a Secretary of the Company, and countersigned by the person receiving the premium. No person has any authority to collect a premium unless he then holds said official premium receipt. With the approval of the Company the premium may be made payable annually, semi-annually or quarterly in advance at the Company's respective premium rates for such modes of payment, upon the written request of the Insured. The payment of the premium shall not maintain this Policy in force beyond the date when the next payment becomes due, except as to the benefits provided for herein in event of default in payment of premium.

3. Privilege of Reinstatement

This Policy may be reinstated at any time within five years after any default, upon receipt of evidence of insurability satisfactory to the Company and payment of overdue premiums with interest thereon at five per cent per annum from their respective due dates. Any indebtedness to the Company which was outstanding at the end of the grace period, with compound interest thereon at five per cent per annum, must be paid, provided, however, that said indebtedness with interest, together with any other indebtedness hereon, if not in excess of the loan value as at date of reinstatement, may remain as an indebtedness subject to the loan provisions of this Policy.

4. Self-Destruction

In event of self-destruction within two years from the date of issue of this Policy, whether the Insured be sane or insane, the insurance under this Policy shall be a sum equal to the premiums hereon which have been paid to and received by the Company and no more.

5. Indebtedness

Any indebtedness to the Company against this Policy shall be deducted in any settlement hereunder.

6. The Contract

This Policy and the application therefor, copy of which is attached hereto, constitute the entire contract. All statements made by the Insured shall,

in the absence of fraud, be deemed representations and not warranties, and no statement shall avoid this Policy or be used in defense to a claim hereunder unless contained in the written application and a copy of the application is indorsed upon or attached to this Policy when issued. No agent is authorized to make or modify this contract, or to extend the time for the payment of premium, or to waive any lapse or forfeiture or any of the Company's rights or requirements. All benefits payable under this Policy are payable at the Home Office of the Company in the City and State of New York, and the surrender of this Policy will be required in any settlement thereof.

7. Incontestability

This Policy shall be incontestable after it has been in force during the lifetime of the Insured for two years from its date of issue except for non-payment of premium and except as to any provisions and conditions relating to Double Indemnity Benefit and except as to any provisions and conditions relating to Waiver of Premium Benefit if the Insured shall become totally disabled within two years from the date of issue of this Policy.

REGISTER OF CHANGE OF BENEFICIARY

NOTE.—No change of Beneficiary shall take effect unless indorsed on this Policy by the Company at the Home Office.

DATE OF REQUEST	BENEFICIARY	INDORSED BY

INDORSEMENTS

NOTE

This copy should be carefully examined and if any error or omission is found, full particulars, with the number of the policy, should be sent immediately to the Home Office, at:

COPY OF APPLICATION

APPENDIX XX

AGENT'S MONTHLY STATEMENT BLANK

MONTHLY STATEMENT BLANK (SHORT FORM)

______________________ AGENT AT ______________________

IN ACCOUNT WITH ______________________ (NAME OF COMPANY) FOR MONTH OF ______________________

FOR COMPANY'S USE	POLICY No.	NAME OF INSURED	GROSS PREMIUMS 15%		20%		25%	
		TOTAL GROSS PREMIUMS —						

FOR COMPANY'S USE	POLICY No.	NAME OF INSURED	RETURN PREMIUMS 15%		20%		25%	
		TOTAL RETURN PREMIUMS —						
		TOTAL GROSS PREMIUMS —						
		TOTAL RETURN PREMIUMS —						
		NET PREMIUMS —						

NOTE: SHOULD RETURN PREMIUMS EXCEED GROSS PREMIUMS IN ANY COLUMN, ENTER NET PREMIUMS IN RED INK OR PLACE MINUS(—) SIGN BEFORE AMOUNT.

AGENT ______ TOWN ______ STATE ______

STATEMENT

DR.			CR.		
TO NET 15% PREMIUMS			BY COMMISSIONS ON NET PREMIUMS @ 15%		
" " 20% "			" " " " " 20%		
" " 25% "			" " " " " 25%		
TOTAL NET PREMIUMS			TOTAL NET COMMISSIONS		
BALANCE DUE AGENT, IF ANY			BALANCE DUE COMPANY		

STATEMENTS MUST BE MADE FOR MONTHLY BALANCES. PAYMENT MUST BE MADE IN BANK EXCHANGE ON NEW YORK OR SAN FRANCISCO, OR IN P. O. OR EXPRESS MONEY ORDERS. AGENTS SHOULD KEEP COPY OF THIS STATEMENT FOR INCOME TAX OR OTHER REFERENCE.

____
SIGNATURE OF AGENT

APPENDIX XXI

SOURCES OF INFORMATION ON INSURANCE CARRIERS, THEIR FINANCIAL CONDITION, WRITINGS, AND RECORD, AND DEVELOPMENTS IN THE FIELD OF INSURANCE

PRIMARY

Offices of the Insurance Commissioners of the Several States (sometimes the title is superintendent).—In these offices are filed as public documents the annual reports[1] of admitted insurance carriers. These reports are open to the inspection of visitors, and members of the staff are usually available to assist in interpretation of the figures.

In some states reports of examinations (audits) of carriers are also public documents and similarly open to inspection. The laws of some states require that, for a time at least, examination findings must be held confidential.

The office also usually has the published annual reports of the insurance commissioners of other states from which information may be obtained about companies not admitted to the state. The commissioners usually receive the published material referred to below as secondary sources. In some offices this material is so filed that visitors may consult it, but it is generally regarded as working material of the office and may not be kept readily at hand for visitors' use.

A citizen unable to visit the office may obtain by correspondence a digest of the data filed by any admitted carrier and other information about insurance. The office will not give opinions about comparative merits of licensed carriers since such action would be regarded as showing favoritism.

Annual Reports of the Insurance Commissioner.—In nearly all states the insurance commissioner prepares and publishes an annual report to the Governor or legislature. These reports usually include summary tables and textual comment on the year under review and in condensed form copies of the annual reports of admitted carriers. They are available in the state library and usually in other public and private libraries.

Carrier Publications.—Many carriers, particularly life-insurance companies, mutual, and reciprocal carriers send annual reports to their policyholders. These reports are condensations of their annual reports to the insurance commissioners with explanatory comments on them and on general economic conditions affecting the company.

Many carriers publish periodical house organs.

Both these sources of information are *original*, but the reader must recognize they are *not independent nor disinterested* sources.

[1] See Chap XXVIII.

SECONDARY

Annual Publications

Best's Insurance Reports, Alfred M. Best Co., Inc. 75 Fulton St. New York, N. Y. Three volumes: Fire and Marine, Casualty and Miscellaneous, Life.

These reports give condensed annual figures for each carrier doing business in the United States, with list of officers and directors, a brief historical sketch, territory in which it operates, and lines of business written.

In connection with the annual statement significant ratios are presented and commented upon.

Best's Insurance Guide with Key Ratings.—This guide is a smaller volume dealing with fire and casualty insurers. Financial figures for the last 5 years are given for each carrier and two ratings expressive of the publisher's appraisal of the carrier set out in form similar to the practice in rating the quality of investment securities. One rating is a "policyholder's" rating based on the record for economy of management, quality of assets, adequacy of reserves, etc. The other is a "financial" rating based on the amount of the surplus to policyholders. The prudent user will probably desire to study these ratings in connection with the data in "Best's Report."

Cyclopedia of Insurance, The Index Publishing Co., 123 William St., New York 7, N. Y.

Information alphabetically arranged in seven sections: fire and marine; life; casualty and surety; texts of important legal decisions concerning insurance regulation from *Paul v. Virginia* to the S.E.U.C. case; definitions of insurance terms; biographical sketches; list of biographies appearing in earlier editions.

The Insurance Almanac, The Underwriter Printing and Publishing Co., 116 John St., New York 7, N.Y.

This almanac contains brief summary material about practically all carriers doing business in the United States, including for each a list of officers and directors, a statement of types of business written, and territory in which it operates. In many cases there is a brief historical sketch and in most cases Dec. 31 figures for the last 10 years showing capital, assets, reserves, net surplus, net premiums written, net losses paid. There is also much other material about insurance.

Insurance Year Book, The Spectator, Chestnut and 56th St., Philadelphia 39, Pa. Five volumes: Fire and Marine, Casualty and Surety, Life, Fire Insurance by States, Casualty Insurance by States.

In these year books data with regard to carriers doing business in the United States are published under several headings: Financial Statements, Historical and Administrative Data, Underwriting and Investment Exhibit (Gain and Loss Exhibit for Life Insurance), Territory, Miscellaneous. The latter includes total business since organization, etc.

In the fire volume the data are assembled in tables under each head with carriers arranged in a systematic order. This arrangement facilitates

comparisons between carriers but the user must examine several tables to get complete information about a given carrier. Other information is given relative to the business of all carriers by type which facilitates comparison of an individual carrier with the average of its type.

In the casualty and in the life volume all the data relative to a given carrier are given in the single entry.

No ratings are given.

Manuals of Rates and Forms

Fire, Casualty, and Surety Bulletins issued by the National Underwriter Co., 420 East 40th St., Cincinnati, Ohio.

These bulletins are a loose-leaf service, revised monthly. They are a compilation of policy forms, endorsements, underwriting rules, and rates for practically all forms of insurance except life and disability. Data refer to general practices, not individual carriers.

Insurance Producers Bulletin, G. Carter Johnson, editor, 6675 Northwest Highway, Chicago, Ill.

This bulletin is a loose-leaf continuous service reporting on changes in forms and practice in all fields of insurance. It is designed for reference work use in brokerage and agency offices. Data refer to general practices, not individual carriers.

Rough Notes Policy, Form, and Manual Analysis Service, The Rough Notes Co., Inc., 1142 N. Meridian St., Indianapolis 6, Ind.

This is a loose-leaf continuous service covering fire and casualty lines. Revision sheets, supplied quarterly, reprint monthly sections of *Rough Notes* magazine. Data refer to general practices, not individual carriers.

In the life-insurance field agents need to have available information about the forms and rates of their competitors, and there are several manuals of generally similar type published for that purpose. Among the best known of these are

Name	Published by
Flitcraft	Flitcraft, Inc., 613 Maple Ave., Oak Park, Ill.
Handy Guide	The Spectator, Chestnut and 56th St. Philadelphia 39, Pa.
Little Gem Life Chart	National Underwriter Co., 420 East 40th St. Cincinnati, Ohio.
Unique Manual-digest	National Underwriter Co., 420 East 40th St. Cincinnati, Ohio.

These manuals are issued annually and reproduce texts or digests of the leading forms of life-insurance policies of each company, the company's rates for the more popular plans of life insurance and annuity contracts, tables of nonforfeiture values, etc.

Monthly Publications

Best's Insurance News, Alfred M. Best Co. Inc., 75 Fulton St. New York. In two editions: Fire and Casualty, Life. Devoted mainly to financial and credit news of the insurance business.

The Casualty and Surety Journal, Association of Casualty and Surety Executives, 60 John St., New York 7, N. Y. Organ of the stock casualty companies. General articles and stock-company items.

Insurance Broker-age, Broker-Age Inc., 90 John St., New York 7, N. Y. Official publication of The Insurance Brokers' Association of New York, Inc. Articles and news of interest to insurance brokers.

Journal of American Insurance, American Mutual Alliance, 919 N. Michigan Ave., Chicago, Ill. Official organ of the mutual companies (other than life). Contains many informative articles of broad scope and items concerning mutual insurance.

The Spectator, Life Insurance in Action. The Spectator, Chestnut and 56th St., Philadelphia 39, Pa.

Weekly and Semimonthly Publications

Most of the weekly and semimonthly journals are essentially trade publications containing matter primarily of interest to persons in the insurance business. They contain in varying degrees articles of general interest about insurance practices, some current data about individual companies, conventions, new forms and practices, personalities in the business, etc. To the insuring public they are of value as a source of information on current problems and trends.

Eastern Underwriter, published weekly by The Eastern Underwriter Co , 41 Maiden Lane, New York 7, N. Y.

Insurance Field, published weekly in two editions: Fire and Casualty and Life, by The Insurance Field Co., P. O. Box 1164, Louisville, Ky.

National Underwriter, published weekly in two editions: Fire, Automobile, and Casualty; and Life, by The National Underwriter Co., 175 West Jackson Blvd., Chicago, Ill.

The Spectator, Property Insurance Review, published fortnightly by The Spectator, Chestnut and 56 St., Philadelphia 39, Pa.

The Standard, Standard Publishing Co., 89 Broad St., Boston, Mass. This journal gives some general news but specializes on the New England field.

Underwriters' Report, published weekly by the Underwriters' Report Inc., 405 Sansome St., San Francisco, Calif. This journal gives some general news but specializes on the Pacific coast field.

United States Review, published weekly by United States Review Publishing Co., 500 Walnut St., Philadelphia 5, Pa. News and general articles.

The Weekly Underwriter, published weekly by The Underwriter Printing and Publishing Co., 116 John St., New York 7, N. Y. Special departments

weekly on each of the major fields of insurance. Contains many educational articles and digests of court decisions in insurance cases.

Daily Papers with Special Insurance Sections

Most financial journals carry some insurance news. The insurance pages of the following are especially useful and well edited:

The Journal of Commerce and Commercial (New York).

Chicago Journal of Commerce.

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